Health Canada Santé Canada

Implementation Handbook

Postpartum Parent Support Program

101-03208/

Implementation Handbook

Published by authority of the Minister
of National Health and Welfare, 1989

Health Promotion Directorate
Health Services and Promotion Branch

Également disponible en français sous le titre
« Programme d'aide postnatale aux parents »

Postpartum Parent Support Program

Originally developed by the Maternal and Child Health Project, St. Joseph's Hospital, Hamilton, Ontario, and further adapted by the Manitoba Post Partum Education Program Committee, Winnipeg, Manitoba, in co-operation with Health and Welfare Canada.

© Minister of Supply and Services Canada 1989
Available in Canada through
your local bookseller
or by mail from
Canada Communication Group-Publishing
Ottawa, Canada K1A 0S9
Catalogue No. H39-153/1-1989E
ISBN 0-660-131552
ISBN 0-660-13154-4 (set)
Reprinted 1994

Table of Contents

Preface 4
How To Use This Handbook 5
Acknowledgements 6

Unit I: Program Overview 7
Objectives 9
Program Components 10
Program Philosophy 12

Unit II: The Postpartum Experience 17
Introduction: Values into Action 18
The Three Phases of Postpartum 19
Theory into Practice 21
The Question of Culture 23
The C.A.R.E. Approach 26

Unit III: For the Educators 29
A Learner-Centred Perspective 31
The Facilitator Role 32
Five Principles for Facilitating a Learner-Centred Approach 33
Questions and Answers 36

Unit IV: Moving into Action 41
Step One: Initiation 43
Step Two: Implementation 52
Step Three: Continuation 62

Appendices 67
1. Project Co-ordinator's Checklist 68
2. Manitoba Health Forms 70
   - Maternal Nursing Data Base 70
   - Newborn Nursing Data Base 71
   - Record of Postpartum Patient Learning 72
   - Guidelines for Inter-agency Referral Forms 73
   - Postpartum Referral Form 74
   - Infant Referral Form 79
3. Evaluation: Sample Staff Questionnaire 84
4. Resource List of Hospitals/Communities that Have Implemented the Program 87

Preface

Welcome to the Postpartum Parent Support Program (PPSP). As someone involved with the implementation of this program, you will have a unique opportunity to work with nurses and other health professionals as they prepare families for and support them during the postpartum period.

During its developmental phase, the PPSP enjoyed considerable success as an innovative and supportive program that supplemented existing resources and also provided new options for maternity care in the health care community. Parents complimented the program for its depth and variety of information while health professionals commented on the reassurance they felt in delivering standardized, well-researched information in a caring and consistent manner.

The preparation of this handbook signifies the last major step in this developmental process; the key to effective use of the program will now depend on health professionals in various communities across Canada, who will adapt the program's resources to their particular situations. With the rapid changes that have taken place in maternity care over the last several years, the PPSP has the potential of providing a dynamic, flexible and well-researched educational program to both families and health professionals.

How To Use This Handbook

This handbook is designed for people who will be involved in implementing the Postpartum Parent Support Program (PPSP). It will be useful to the project co-ordinator, committee members, hospital and community health nurses, inservice educators and others who will be working with the program.

The handbook is structured into four units. Unit I provides an overview of the program, focussing on family-centred maternity care and the program resources. Unit II provides information about the postpartum experience so that multi-agency health professionals will be working from a common base of understanding about this period. The third unit presents the adult education principles on which the program is delivered.

Unit IV, the last unit, puts all of the previous information together into three major action steps: Step One – initiation of the program in your health community; Step Two – implementation of the program; and Step Three – continuation, or how to ensure that the program will continue to renew itself over time. The Appendix provides further documentation to support each of these steps.

It is designed to be a resource package, a reference manual and a workbook, allowing the users the flexibility to adapt the ideas and suggestions to their unique situation. There is no "right" way to implement the PPSP; its use is governed by the support and limitation of the individuals and systems in their own communities.

Notes: Terms vary across Canada. In this handbook, "community health" may refer to "public health" or a variety of agencies. Other terms are defined in the Appendix.

The handbook is set up so that users can photocopy sections.

Acknowledgements

The Postpartum Parent Support Program is based on a program developed by St. Joseph's Hospital, Hamilton, Ontario, with funding from the Contributions Fund of Health Promotion Directorate, Health and Welfare Canada. The program was subsequently recommended for national dissemination. The following organizations participated in the pilot testing phase:

a) Community health unit of le Centre hospitalier de Chicoutimi, Chicoutimi, Québec, in conjunction with:
- le Centre hospitalier de Chicoutimi;
- le Centre hospitalier de Jonquière;
- le C.L.S.C. Saguenay-Nord;
- le C.L.S.C. de Jonquière;
- le C.L.S.C. de Jonquière (Arvida);
- le C.L.S.C. des Côteaux

b) A multi-agency committee in Winnipeg, Manitoba, consisting of:
- Grace General Hospital;
- Misericordia General Hospital;
- St. Boniface General Hospital;
- Victoria General Hospital;
- Women's Hospital;
- City of Winnipeg Health Department;
- Winnipeg Region, Manitoba Health Department.

c) St. Rita Hospital, Sydney, Nova Scotia, in conjunction with the Nova Scotia Department of Public Health

We wish to thank these agencies for their contribution to the nationalization of this resource. Acknowledgement is also extended to the Advisory Committee on the Postpartum Parent Support Program for its recommendations on how to implement the program nationally. Many other people, too numerous to mention individually, have contributed their expertise to the pilot testing and to the development and revision of the resources. To them we extend our gratitude.

Finally, a special thank you goes to Dr. Donna Mitchell and Mrs. Valerie Adam who carried out the early development and writing of the resources, and to Dorothy Strachan and Paul Tomlinson who wrote the final version of the Implementation Handbook for the program.

Illustrations throughout the Implementation Handbook, the Staff Reference Manual, "Help Us to Help You" and the information sheets are by Suzanne Labelle.

Unit I:

Program Overview

Attitudes and expectations of Canadians to do with childbirth are constantly evolving. Not many years ago, general anesthetics, extended hospital stays and mother-child separation were simply part of what happened in most parts of Canada. Today, with an emphasis on "natural" childbirth, family involvement, shortened hospital stays, birthing rooms, the promotion of breast-feeding and rooming-in, many of the old rules and expectations are changing.

The educational process for families and health care professionals has been slow to catch up to these new trends. Many mothers and their families have been reading the "latest" information in popular magazines and are confused about what is best for whom and why and when and where.

The Postpartum Parent Support Program (PPSP) has evolved as a result of this need for clear, well-documented answers to the many questions that parents, family members and health professionals ask. The success of the program is largely because of its ability to deliver consistent, well-researched answers to parents' questions throughout their postpartum experience. Because the program is designed for the entire home-hospital-home continuum, parents who become part of the program will receive basically the same answers to questions they ask of a nurse in the postpartum ward or a community health professional visiting them in their own home.

Objectives

The PPSP has two target groups: families of newborn babies and the health professionals involved with them. The program's objectives are:

To assist parents and other immediate family members to:

- develop feelings of competence and confidence about the postpartum period;
- set realistic expectations about coping with a new baby;
- develop the skills and knowledge required for new parenting roles;
- identify and use support persons and resources during the postpartum period;
- acknowledge and understand the uniqueness of their new child;
- integrate the "new" baby and "new" mother into a "new" family.

To assist health professionals in the hospital and surrounding community to:

- provide accurate, up-to-date and consistent information about the postpartum period;
- develop confidence and competence as adult educators working with families in stressful situations;
- provide assistance to new parents in the development of their parenting skills;
- build a team that can deliver high-quality information in a consistent manner throughout the home-hospital-home continuum.

Program Components

Key players	*Resources*
Parents and babies	A list of questions for parents; various information sheets on topics such as circumcision, care of the umbilical cord, formula preparation, etc.
Immediate families and friends	Colouring book for siblings: "I'm Here." Various information sheets for parents and grandparents.
Hospital and community health professionals	A list of questions for parents; a staff reference manual that provides consistent answers to the questions on the list; a bibliography and reference list of available and up-to-date printed and audiovisual materials on breast-feeding and the postpartum period.
Project co-ordinator	An implementation handbook for the PPSP.

Each PPSP kit consists of five items:

1. An implementation handbook for the program;
2. A staff reference manual (The Resource Book) for health professionals;
3. A list of questions for parents;
4. Information sheets on a wide range of topics;
5. A colouring book for siblings.

1. An Implementation Handbook for the Program

The purpose of this handbook is to provide a guide for those involved in implementing the PPSP, and in particular for the project co-ordinator, one of the people instrumental in this process.

This handbook does not try to offer a single approach that works best in all settings. Rather, it is the reader's responsibility to adapt the ideas presented to suit each individual situation.

Whatever your particular situation, the PPSP has been enthusiastically received by both health professionals and the general public in a number of large and small, urban and rural settings.

2. Staff Reference Manual (The Resource Book)

The Staff Reference Manual contains well-researched and standardized responses for each question on the list that is given to the parents and is mainly for the use of health professionals. Its major purpose is to encourage dialogue between the client and the care giver and to increase the consistency and accuracy of information given to parents by all of the health professionals they encounter both in the hospital and in the community. A list of educational resources on breast-feeding and the postpartum period is also included.

3. A List of Questions for Parents

This list, called "Help Us to Help You," consists of more than 180 commonly asked questions that are answered in the Staff Reference Manual.

The list is given to mothers after they leave the birthing area or, in the case of scheduled Caesarean surgery, when they enter hospital. They are encouraged to check questions they would like answered, as they become important to them. The questionnaire allows parents to control the content of the teaching and explicitly encourages them to ask questions they may have been hesitant about asking or unable to articulate. Nursing staff in hospitals check with parents regularly to see if they have any questions. Parents are encouraged to take the questionnaire home with them; community health nurses can reinforce the answers given by hospital nurses and answer any new questions that arise.

4. Information Sheets

Some topics, either because they contain a considerable amount of detailed information or because they are emotional in nature, are supported by a handout for parents. Concise information sheets are available for the following topics:

- Caesarean Birth
- How to Collect and Store Breast Milk
- Formula Preparation
- Jaundice
- Bathing
- Cord Care
- Circumcision
- Making Your Home Safe For Children
- Keeping Children Safe in the Car
- Postnatal Exercise
- Especially for Grandparents

These sheets help support the learner-centred philosophy that is the major focus of the PPSP. Your agency may also want to consider producing other information sheets such as "Available Community Services," "Single Parents," "Rooming-in," "Pastoral Care" and the "Sick Newborn."

5. Colouring Book

The colouring book, "I'm Here," is a gift for siblings which emphasizes their importance. This resource incorporates the themes of attachment to the new baby, information about newborns and ways to interact with the baby.

It is designed as a tool to encourage sibling interaction. Keep in mind that how well the child can colour is unimportant; what matters is the understanding of the book's content and the interaction encouraged with other family members.

Suggestions for Use of Information Sheets

Information sheet	*Given to*	*When distributed*
Caesarean Birth	Mothers delivered by Caesarean section	Day before elective Caesarean, after emergency Caesarean section birth, or as needed
How to Collect and Store Breast Milk	Breast-feeding mothers	In hospital or at home, as needed
Formula Preparation	All formula feeding parents	In hospital
Jaundice	Parents of jaundiced babies	Preferably before parents see their baby under lights
Bathing	Parents who request it or seem anxious	After the bath demonstration
Cord Care	All parents	In hospital or at home
Circumcision	Parents who are uncertain about circumcising male infant	As needed
Making Your Home Safe for Children	All parents	In hospital or at home, as needed
Keeping Children Safe in the Car	All parents	In hospital or at home, as needed
Postnatal Exercise	Mothers	In hospital
Especially for Grandparents	Grandparents and parents	In hospital or at home, as needed

Program Philosophy

Family-Centred Maternity Care

Family-centred maternity, newborn and early childhood care may be defined as the delivery of safe, quality care of both the physical and psychosocial needs of the mother, the father, the child, and the family. The frame of reference is health rather than illness in an environment in which childbirth is appreciated as the basis of family development, and the family, as the cornerstone of society.[1]

The PPSP is guided by this philosophy. As such, there is a clear emphasis on the involvement of the entire family in the complete birthing process. In addition, every attempt is made to provide continuity and consistency in care and information provided from the pre-pregnancy and prenatal period, through labour and birth, to the conclusion of the postpartum period.

Family-centred maternity care functions well in a health care environment where the following values are understood and operative:

- the family is the basic social unit of our society;
- a positive postpartum experience is crucial to both the initiation and continuation of healthy parent-child, partner and sibling relationships;
- the health care system plays a major role in preventing potential physical and psychosocial problems during the vulnerable postpartum period and in promoting positive, nurturing relationships among all those involved.

In many hospitals, family-centred care translates into the following practices:[2]

- babies room in with their mothers;
- demand feeding is available;
- combined-care nursing is in practice, where the nurse taking care of the mother also cares for the baby;
- siblings can be present in the recovery area;
- fathers are welcome to be with mother and the baby and are encouraged to develop baby-care skills;
- other immediate family members and/or close friends are encouraged to hold the baby and to begin to get to know him/her;
- birthing rooms are available with relaxed and comfortable atmospheres to get away from a clinical setting;
- social services personnel are available to assist families;
- planned social, educational and resting times are available for mothers.

Many people have written about the successes achieved in obstetrics over the last 40 years: the invention of penicillin, antibiotics, plastic bassinets, efficient plumbing, anesthetics, sophisticated measures for infants in distress – the list goes on and on. But as the renowned maternity nurse Reva Rubin pointed out in 1975, the postpartum experience has not been very well handled in North America.[3] Neither obstetrical nor pediatric medicine have seemed overly concerned or knowledgeable about postpartum problems. Rubin described the North American myth of motherhood – that once the baby is born, everyone lives happily ever after – as a belief that suffers from misstatement, understatement and wholesale neglect.

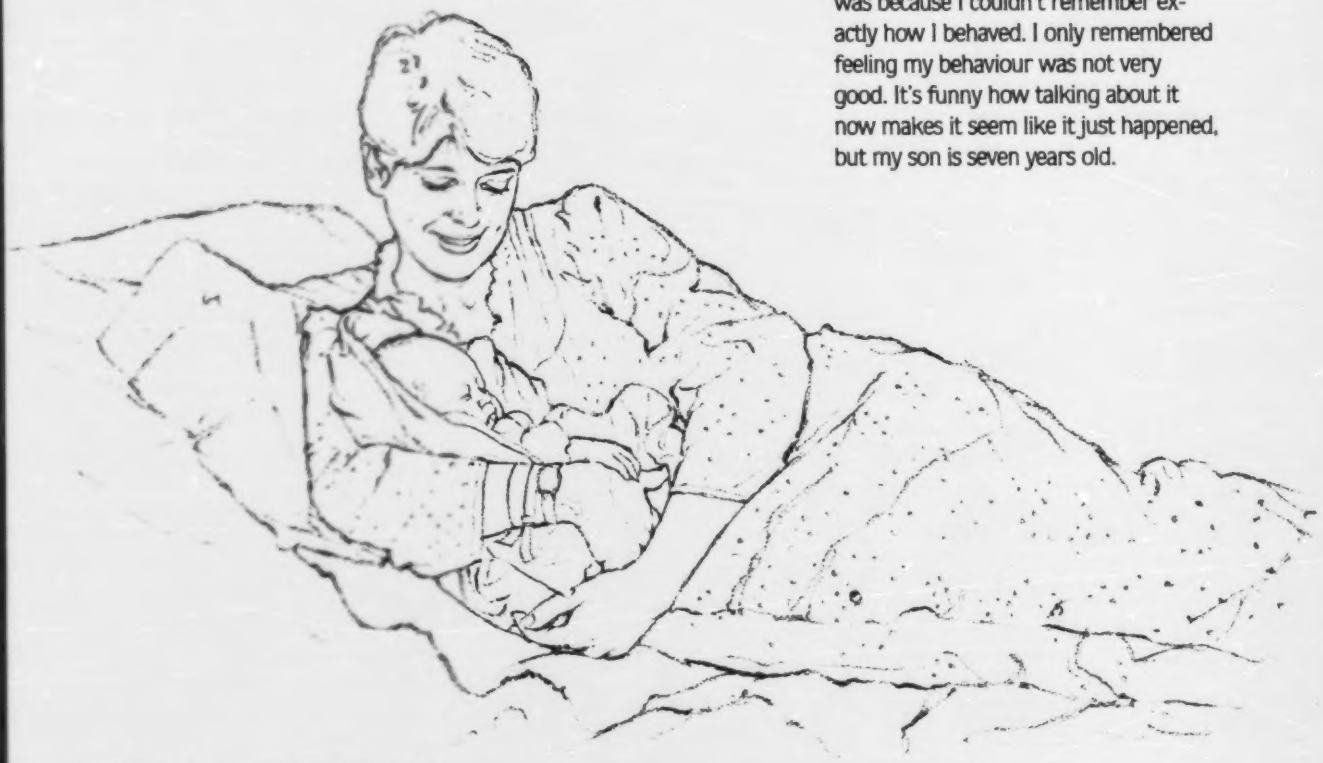
Mothers have also written about the emotional states during this difficult period (see opposite).

The PPSP helps to address some of these situations in a constructive and well-organized manner by providing resources for health professionals to use in working with parents during the postpartum period – resources focussed on a family-centred philosophy of maternity care. This involves a multi-agency approach with a variety of individuals delivering the same information in a caring and professional manner. When the program is operating well, as it does currently in a number of centres across Canada, parents receive continual support and consistent education throughout their prenatal, birthing and postnatal experiences.

For the purposes of the PPSP, a multi-agency approach involves the co-ordination and education of a number of

I have this dominant impression of being overwhelmed by the mystery and joy of the whole process. When I think back to it now, there was a constant feeling of unreality, as if I was in a dream and that the whole idea of a new baby that started from a microscopic seed could possibly develop into a person. It took me about two wonderful years to acknowledge the reality of the whole thing.

I can remember right after my son was born thinking for weeks about what had happened. I have never admitted this to anyone, but I really wasn't interested in him during those initial weeks. I found myself preoccupied with thinking about why I couldn't control myself during labour as I had wanted. It was because I couldn't remember exactly how I behaved. I only remembered feeling my behaviour was not very good. It's funny how talking about it now makes it seem like it just happened, but my son is seven years old.



I kept feeling as if I was in a dream. And that all my friends had hidden the true facts about what would happen. I hurt everywhere – breasts, bottom, even when I was walking. Sometimes it seemed like a nightmare. And then to top it all, she was irritable, crying at least three hours every evening. I often felt I just wouldn't last. I was also trying to do some work at the same time so I was exhausted for about six months.[4]

I wasn't exactly depressed but I wasn't happy either. My family lived 500 miles away and I felt so alone. Michael helped but he couldn't share my "woman's" feelings. He would never know how I felt. His efforts to support me were so male, so inexperienced with this whole thing. I wanted a perfect mother to hold me forever, and it just didn't happen.

health professionals in the community. The primary emphasis is likely to be with maternity nurses and community health nurses although in some areas, prenatal class instructors and home care volunteers are also involved.

With the length of hospital stays becoming shorter and shorter for normal deliveries, the role of health care professionals outside the hospital is becoming more important. Mothers who stay in hospital only two or three days will likely have completely different needs when at home than those who stay for five to six days. For this reason, community health professionals play a large and vital role in making the PPSP a success.

A Learner-Centred Philosophy

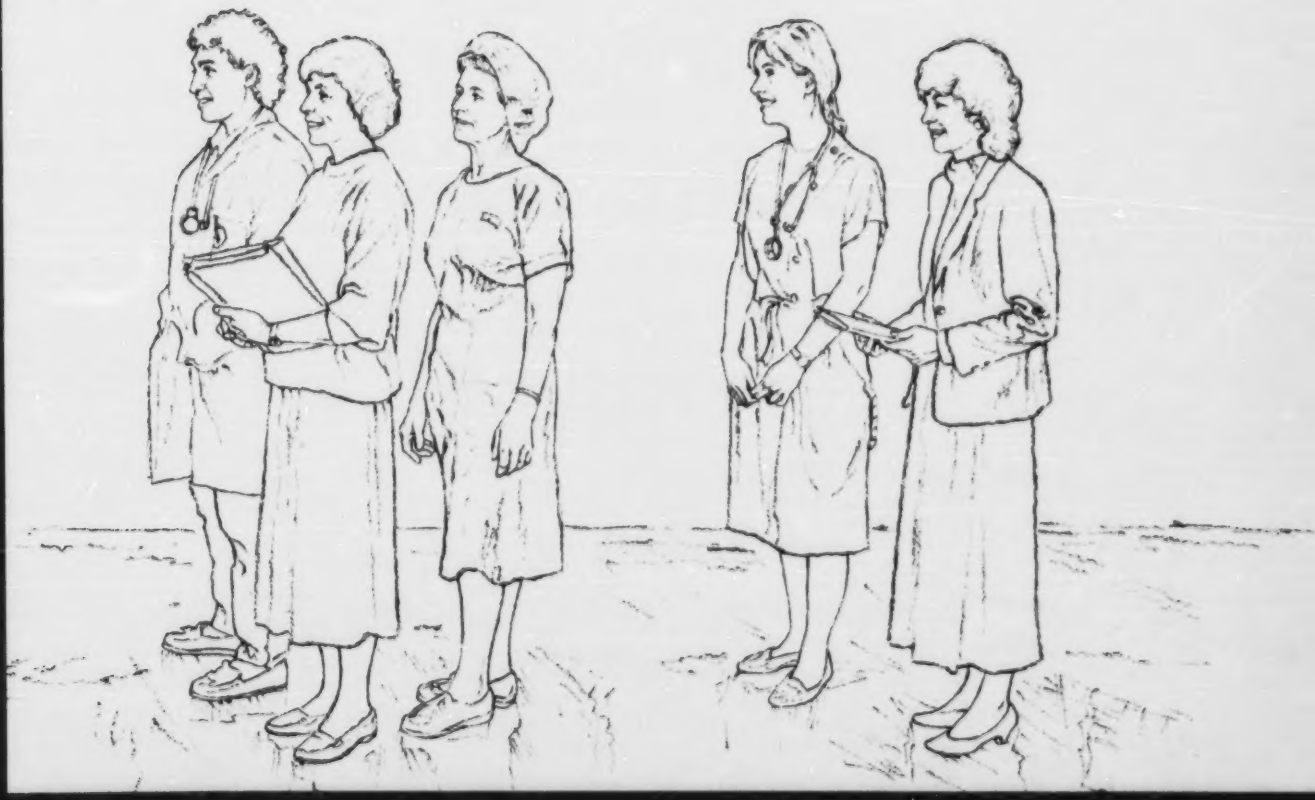
Parents benefit most from the PPSP since most of the materials used in the program help them in becoming more comfortable in their "new beginnings."

Mothers come into maternity care with a wide variety of backgrounds, experiences and personal histories. Regardless of their formal education levels, they will have a wide-ranging list of needs and interests related to their new roles. This program is designed to meet each parent's unique needs and is set up so that parents can tell a health professional exactly what they want to know, without getting into areas that they are already familiar with or not yet ready to learn.

The list of questions that the mother or father checks off is an example of how learning is tailored to specific needs – i.e., it is centred more on the parents' requirements and less on the health professional's idea of what they ought to learn. It is based on the parents' ideas about what they want to discuss and learn, not the expert's interpretation of what they should know.

A learner-centred philosophy in educational programs presents some unique challenges to nurses. Where some nurses have been used to designing baby classes ahead of time and delivering them to mothers without asking what the mothers wanted to know, they now must tailor information to suit each individual's needs. This means that the nurse must attend just as closely to the *process* of what is happening as to delivering the right *content*. It also assumes that the nurses will be skilled in answering and asking questions, helping the parents feel at ease with sensitive topics and facilitating their learning in the most supportive way possible. It is important for all health professionals involved with the PPSP to understand fully both the process and content of learner-centred programs.

Once you have a feeling for the program in general and what it can offer families in your community, your next step is to appreciate the intricacies of the postpartum period – the subject of the next unit.



References

1. From an information paper produced by the Canadian Institute of Child Health as a follow-up to their original report *Prevention of Handicap: A Case for Improved Prenatal and Perinatal Care*, 1978.
2. Ibid., adapted.
3. Rubin, Reva. "Maternity Nursing Stops Too Soon." In *American Journal of Nursing*, October 1975, p. 1684, paraphrased.
4. Alfonso, Dyanne. "Missing Pieces – a study of Postpartum Feelings." In *Birth and the Family Journal*, Vol. 4, No. 4, Winter 1977, p. 162.

Further Reading

Canadian Institute of Child Health. "Family-Centred Maternity, Newborn, and Early Childhood Care in Canada." An information paper to follow-up to the original report, *Prevention of Handicap: a Case for Improved Prenatal and Perinatal Care*, published in 1978. Available from the Canadian Institute of Child Health, 17 York Street, Ottawa, Ontario.

Clark, Ann and Dyanne D. Alfonso. "Mother-Child Relationships." In *The American Journal of Maternal Child Nursing*, March/April, 1976, pp. 94–99.

Dossin-Shanahan, Denise and Sharon Bradley-Johnson. "The Need for Parent Education: A Survey of Mothers in Maternity Wards." In *Infant Mental Health Journal*, Vol. 1, No. 2, Fall 1980.

Mercer, Ramona T. "The Process of Maternal Role Attainment over the First Year." In *Nursing Research*, Vol. 34, No. 4, August 1985.

Unit II:

The Postpartum Experience

Introduction: Values into Action

Understanding the postpartum experience is essential to effective implementation of the PPSP. Pregnancy, childbirth and the postpartum period are three of the most stressful periods that most women will experience in their lifetimes. Each mother's ability to cope with these experiences will depend to a great extent on the quality of care she receives during the prenatal, birthing and postpartum periods.

The Canadian Institute of Child Health[1] recommends that for effective postpartum care, the values inherent in the physical and emotional closeness of a family-centred birth should be incorporated into the philosophy of the birth-unit staff. At the same time, both the scientific and technological tools and the expertise of modern obstetrical practice should be made available to each family as needed. In family-centred maternity units, special attention is given to the importance of support for such factors as:

- maximum freedom for the mother during labour;
- normal birth in the same room in which the mother labours;
- comfortable positioning during both advanced labour and the birth itself;
- presence of one or two support people for the labouring mother;
- promotion of early attachment and breast-feeding;
- support for the new family during the mother's confinement, involving the father or another support person during labour and birth, and liberal attitudes towards visitors, including grandparents and siblings;
- concentration of active medical intervention on those mothers whose pregnancy, birthing, or infant deviates from the norm, while at the same time providing these women and their families with needed additional emotional support;
- comprehensive screening for possible physical, psychosocial and socio-economic risks with the initiation of long-term planning, including appropriate referral.

Health professionals who know that a mother and her family will go through identifiable phases during the postpartum period are better prepared to help the mother and her family as they experience each phase in their own unique ways, as described in the next section.

The Three Phases of Postpartum

Researchers[2] have commented on the general predictability of phases that mothers experience throughout the postpartum period. As a rule, these researchers are quick to point out that the postpartum period actually involves the fourth and fifth trimesters of the maternity process and that to abandon a mother too soon leaving her without the support of health professionals can contribute to a multitude of psychological and physical problems. With shortened hospital stays, reduced family support and fewer staff members in hospitals and communities across Canada, the importance of providing continuous, consistent, high-quality care throughout the entire postpartum period cannot be overemphasized.

The postpartum period is an important transitional time for the new mother, her baby and the family as a whole. By being sensitive to how a mother is dealing with these changes, nurses can help her in a positive way in order to aid family members in coping.

Although it is not as well documented or articulated, other family members also experience phases of adaptation during the postpartum period. A family-centred approach recognizes this reality and encourages sensitivity and guidance on the part of health care workers.

The Three Phases of Postpartum

Phase	*1 Taking in*	*2 Taking hold*	*3 Letting go**
Average time span	2 to 3 days	3 to 14 days	15 days to 6 months
Dependence continuum	• dependent: "help me, hold me"	• independent: "I've got to help myself"	• interdependent: "We're all in this together"
Body image	• massive physical changes in a short period of time: out of touch or can't keep pace with many of the physical adaptations taking place	• body image in transition: feelings swing from disbelief to beginning acceptance; concerns regarding sexuality are present	• settling into the reality of a new physical self; increasing acceptance of a changed body; physical image still changing
Energy	• very low, need for additional sleep and food • may also experience an artificial high during this time	• tired but more alert, eager to get on with mothering • stronger desire to take care of infant	• still tired but accepting new demands on the family • adjusting priorities to accommodate the new situation
Power and control	• need to lean on experts and others who have experience and know-how • strong need to be mothered	• need to take charge of the new relationship • recognition of the dependence of the baby and its need for mothering • mother's need for mothering continues to be strong	• feelings of empowerment start; more confidence and control • need for peer acceptance of how mothering is done
Communication	• very talkative: needs to discuss the birth experience in detail; often vague about certain aspects of birth; needs to fill in these missing pieces	• needs to discuss expectations of birth and baby and how they compare with reality • needs to discuss issues such as functions, infant care, sibling rivalry, etc.	• needs sensitive discussion of new role, expectations regarding work at home and outside the home • needs to know about resumption of sexual activity; needs to understand changing sexual feelings and needs
Emotional state	• vulnerable, feels a victim of her body, changing circumstances and relationships	• vulnerable to rejection, rapid and frequent mood swings • large hormonal changes	• integration of the new experience into everyday reality • increasing acceptance and appreciation of the new state of affairs • a feeling of being able to cope • improved self-esteem

*The duration of the third phase is being redefined. It is generally recognized now that a six-week physical recovery period is no longer valid. Instead, the literature refers to the "fourth trimester" or a minimum of three months for physical and psychosocial recovery. Many writers describe Phase 3 as a year in length due to the time needed to integrate the new child into the family.

Theory into Practice

Read the quotations in the left-hand column, keeping in mind the possible implications of this information for how you will implement the PPSP in your hospital community. Jot down your ideas in the column at the right.

What the literature says	*Implications for the implementation of this program*
The literature identifies critical factors related to teaching postpartum mothers such as timing of instruction, repetition and learner-readiness. With the trend for early hospital discharge, readiness for learning may occur after the mother is home.[3]	
Eighty-five percent of the women in one study said that there were events they could not remember about their labour or delivery and that they wanted more information about what they could not recall. Women said that they often found themselves thinking about what they could not remember.[4]	
Eighteen times as many women are admitted to mental hospitals in the first month of postpartum as in each month of pregnancy.[5]	
Women who have not integrated certain experiences of their labours and deliveries frequently verbalize recurrent, repeated themes. For example, the women may ask the same question over and over to one person, or may ask the same question to different persons such as the nurse, doctor, husband, or even the cleaner who enters her hospital room. Certain situations such as a long labour, a rapid labour, a high-risk condition, unfulfilled expectations or medications may make women forget chunks of their childbirth experience. Consistent answers delivered in a patient tone can reassure mothers in this position.[6]	

What the literature says	*Implications for the implementation of this program*
We label a newly-delivered mother as "normal" when she is discharged after giving birth, when she is anything but! She has massive loss in circulating blood volume. We would admit any other person to the hospital for such a condition and prepare for possible cardiac arrest. She has profuse diaphoresis. We would start I.V.s and worry about blood chemistries in anyone else with so much diaphoresis. She has profound weight loss. We would admit her in a matter of hours. She has massive displacement of internal organs suddenly and precipitously with a consequent loss in function. We would admit any other person for evaluation, bed rest, and careful observation with the same condition. Each symptom is severe, an emergency situation for anyone else, an accident perhaps. But not by accident in the maternity experience. On the contrary, very normal for a woman who is postpartum.[7]	
The infant's birth ushers in a critical phase for the mother in relating to her child, because it forces her to compare her real-life baby with her dreams, fantasies, and expectations. Maternal behaviours are prompted when reality and her expectations of the baby are congruent. But if there are discrepancies, interaction between mother and child is delayed because the mother must first work through the grief of losing the fantasized or dream child.[8]	

The Question of Culture

Changes in the cultural makeup of Canadian society have important implications for postpartum services and education. Different cultures have very diverse definitions of the term "postpartum," – varying from the length of the postpartum period, family roles and support systems through acceptable hygiene practices and beliefs. Sensitivity to these cross-cultural differences can facilitate a positive experience for the family involved.

The chart below explores the range of childbearing and child-rearing practices you may observe in implementing this program in your community.

Pregnancy

Seek prenatal care	Late	Early
Prenatal education	Non-attenders Non-readers	Attenders Readers
Remedies for common discomforts	Home remedies	Professional cure

Many factors, such as ethnically mixed marriages and socio-economic status, have an influence on cultural tendencies in birthing and infant-care practices. Listen to people (mothers) as they tell you what is important to them, being sensitive that their beliefs and practices are an integral part of who they are and how they feel, react and learn.

Think about the ethnic groups that your hospital/community health system services. Is someone from your agency available to communicate with them in their first language?

_____

_____

_____

_____

_____ _____

Postpartum

Differences in hygiene practices

_____

Ritual washing — Not concerned

Rest in puerperium

_____

Important — Not important

Extended family involvement

_____

High — Low

Sexual activity

_____

Restrict — Resume

Are representatives from ethnic communities invited to explain rituals to the staff?

How might you find out more about perceptions of the postpartum period?

Baby Care

Method of feeding

Weaning

Belief and rituals about cord

Bodily contact and hugging

The C.A.R.E. Approach

Health care professionals working towards family-centred maternity care often feel hampered by advocating a "wellness" philosophy in the midst of an environment that is centred on ill'ness. One way to encourage a continuing focus on wellness is to put the C.A.R.E. approach into practice. This method emphasizes behaviour on the part of health professionals that will *confirm* the legitimacy of the family's experience, *attend* to family members as unique and responsible individuals, teach the mother how to *reflect* on her experience and integrate it into her life history and *empower* family members to feel that they are capable and in control of the major decisions to be made about medical care throughout the prenatal, birth and postpartum period.

C – Confirmation
A – Attention
R – Reflection
E – Empowerment

More specifically, this approach asks health professionals to help a mother move through the three postpartum phases, encouraging her to do it within her own time, space, cultural values and intuitive responses. Here are some suggestions for how this might happen. Add your own ideas to those already provided.

The role of the health professional is to facilitate *confirmation*:

- that a mother's feelings are legitimate;
- that each birth and postpartum experience is unique, although there may be some basic patterns;
- that pregnancy, birth and postpartum are stressful for women;
- that overwhelming fatigue is a natural result, and resting is a legitimate pastime;
- that it is difficult to reconcile an old body image with a new one; and
- that fathers and siblings also experience a variety of confusing feelings throughout this period.

The role of the health professional is to *attend*:

- to each mother's unique experience and her feelings about it;
- to each family's socio-economic and cultural situation and how that may influence their experience of the postpartum period;
- to each mother's need for discussion and interaction with caring health professionals;
- to individual concerns about changing body image and self-concept; and
- to needs for attention from other family members

The role of the health professional is to encourage *reflection*:

- on how individual expectations were fulfilled or unfulfilled during labour, delivery, postpartum;
- on how to integrate the new baby with other family members;
- on the importance of establishing the mother's identity as being separate and worthwhile aside from her role of nurturing the baby;
- on how the father's role will change as a result of the new baby; and
- on how priorities will change at home with a new baby and the additional workload that implies.

The role of the health professional is to help family members to feel *empowered*:

- to deal with difficult emotional stress in a highly anxious situation;
- to consider problems related to daily living and make decisions that suit them best;
- to function as mature and capable adults in the context of a changing family situation; and
- to make decisions based on the information they receive.

What positive, driving forces exist in your hospital or community health system that will support a C.A.R.E. approach?

What could you do to build on these positive forces?

What non-supportive, restraining forces exist in your system that will hamper a C.A.R.E. approach?

What might you do to reduce the impact of these restraining forces?

References

1. The ensuing recommendations are taken from an information paper titled "Family-Centred Maternity, Newborn and Early Childhood Care in Canada" produced by the Canadian Institute of Child Health, Suite 105, 17 York Street, Ottawa, Ontario K1N 5S7, 1980.
2. The information about phases during the postpartum period is adapted from four primary sources:
   i. Articles written by Reva Rubin, especially "Puerperal Change." In *Nursing Outlook*, 1961, Vol. 9, pp. 753–755 and "Maternity Nursing Stops Too Soon." In *American Journal of Nursing*, October 1975, pp. 1680–1685.
   ii. Hans, Anna, "Postpartum Assessment – The Psychological Component." In *JOGNN*, January/February 1986, pp. 46-51.
   iii. Buchan, Norma, Consultant in Maternal and Child Health, "Consistency in Postpartum Teaching." (unpublished) Manitoba Health, 1984.
   iv. The personal experience of the writer (Dorothy Strachan) as a multipara mother.
3. Bull, Margaret and Donna Lawrence. "Mothers' Use of Knowledge During the First Postpartum Weeks." *JOGNN*, July/August 1985, p. 316.
4. Alfonso, Dyanne D. "Missing Pieces – A Study of Postpartum Feelings." In *Birth and the Family Journal*, Volume 4, No. 4, Winter 1977, p. 159.
5. "Postpartum mental disturbances and hormone changes." In *British Medical Journal*, Volume 290, April 27, 1985, p. 1232.
6. Ibid., p. 161.
7. Rubin, Reva. "Maternity Nursing Stops Too Soon." In *American Journal of Nursing*, October 1975, p. 1684, paraphrased.
8. Clark, Ann and Dyanne Alfonso. "Mother-Child Relationships." In *The American Journal of Maternal Child Nursing*, March/April 1976, p. 96.
9. Yoshida, May and Mary Davies. *Ethnocultural Differences in Parenting: Similarities and Differences in Childbearing and Childrearing.* University of Toronto, Faculty of Nursing Alumni Association, 1985. A flip-file, condensed from a book.

Further Reading

Dooley, Barbara, Janice Prochaska and Patricia Klibanoff. "What Next: An Educational Program for Parents of Newborns." In *Social Work in Health Care*, Vol. 8, No. 4, Summer 1983, pp. 95–103.

Haggerty, Robert and Philip Darney. "Maternal and Child Health Services." In *Public Health and Preventive Medicine*, John Last, ed., 11th Edition, 1980.

Hanford, Penny. "Postpartum Depression: What Is It, What Helps?" In *The Canadian Nurse*, January 1985, pp. 30–33.

Interprofessional Task Force on Health Care of Women and Children. "The Development of Family-Centred Maternity/Newborn Care in Hospitals". Joint Position Statement. *Journal of Obstetrics, Gynecologic Neonatal Nursing*, 1978, Vol. 7, p. 55.

Jordan, Bridgitte. *Birth in Four Cultures.* Montreal: Eden Press, 1983.

Ludington-Hoe, Susan. "Postpartum: Development of Maternicity." In *American Journal of Nursing*, July 1977. pp. 1171–1178.

May, Katharyn Antle. "Three Phases of Father Involvement in Pregnancy." In *Nursing Research*, Vol. 31, No. 6, 1982, pp. 337–342.

Mercer, Ramona T. "She's a Multip... She Knows the Ropes." In *MCN*, Vol. 4, September/October 1979, pp. 301–304.

Moss, Jean Russel. "Concerns of Multiparas on the Third Postpartum Day." In *JOGNN*, November/December 1981, pp. 421–424.

Stern, Gwen and Laurence Kruckman. "Multi-disciplinary Perspectives on Postpartum Depression: An Anthropological Critique." In *Soc. Sci. Med.*, Vol. 17, p. 1027.

Weiser, Angie and Patricia Castiglia. "Assessing Early Father-Infant Attachment." In *MCN*, March/April 1974, pp. 104–106.

Unit III:

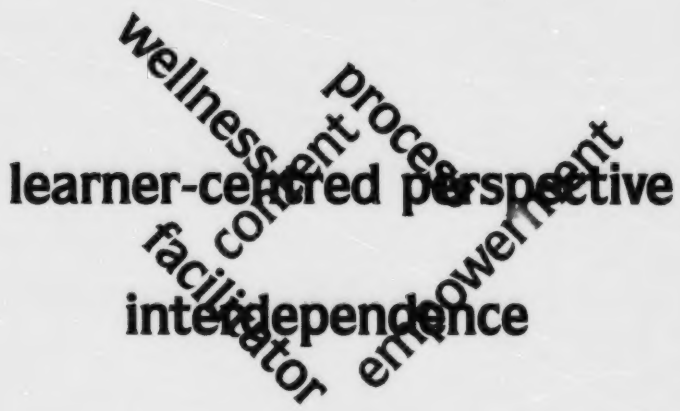
For the Educators

Integrating new programs into existing systems involves a lot of change for people in educational roles. And in the PPSP, everyone involved is an educator in one way or another, with the project co-ordinator particularly needing to be aware of educational requirements. In addition to the rather informal education that takes place among committee members or in presentations to management groups, there is the more formal "Inservice" training of health care professionals who will in turn teach their clients.

This unit provides an overview of the educational perspective of the program and shows how this perspective permeates both the formal and informal aspects of the program. The materials in this unit are designed to be photocopied as handouts for inservice education.

A Learner-Centred Perspective

A number of elements of the PPSP make it innovative in health care. For one thing, it is a "wellness" program that operates largely in an illness-oriented environment. For another, the request for information comes from the clients, who primarily determine the content and have significant control over the process of how the answers are given. Traditionally it has been the health professional who has made all the decisions about what patients should know, as well as when and how they should learn it. This approach no doubt gave rise to the old saying that to be in a hospital it was absolutely crucial for "patients to have patience" just to get through their day-to-day encounters with well-meaning but highly controlling personnel.



In a learner-centred approach, this issue of control is a key one. The emphasis is on educators recognizing the validity of the clients' background and experience and then helping clients to feel able to handle their own situations. Educators who work within this context of **empowerment** focus on sharing control of both the **content** (what the clients should know) and the **process** (how they will learn it). This is true both for hospital and community health nurses working with maternity clients and inservice personnel who are training nurses to deliver the program.

A learner-centred approach also emphasizes **interdependence** in the learning situation. The nurse should know where the mother sees herself within the context of her postpartum experience. Is she "Taking In," "Taking Hold" or "Letting Go"? And how can you work with her to **facilitate** her development by meeting her learning needs? The key point here is that nurses work with clients to accomplish both their mutual goals and those of the program; this requires much sensitive and respectful interaction. For this reason, the words "nurse" and "facilitator" are interchanged throughout this unit.

The Facilitator Role

Effective facilitators deal with two main areas – the content, or subject matter, and the process, or dynamics, that takes place as clients deal with this content. It takes a radical shift in perception to move away from seeing yourself in a traditional teaching role towards seeing yourself as someone who works with others to make learning easier. Because most people in Canada have been educated in a teacher-centred, traditional, learning situation, it is easier to slip into that mode than to focus on developing new skills and approaches.

Becoming an effective facilitator means constantly asking the question: "How do I focus on what is happening for the learner right now?" It also involves helping clients to take in new information and then to make their own personal meanings out of it. Another way to say this might be that as children, we see that learning is based on forming ideas, information and concepts; as adults we see it more in terms of transforming the same information, ideas and concepts so that they make sense in an adult world.

A learner-centred approach offers both these forming and transforming experiences – both cognitive content and the opportunity to develop personal meaning out of that information. With the wide ethno-cultural backgrounds and experiences of clients involved in the PPSP, it is crucial to help them interpret the content of the program according to their unique situations, rather than to force them to see it the way a single nurse might present it.

Comparison of Perspectives: Teacher/Facilitator[1]

Traditional perspective: teacher role	*Learner-centred perspective: facilitator role*
Main focus is on presenting content.	Main focus is on how to make the content mean something to learners.
Basic approach is "Here is what you need to learn and here is how we are going to do this."	Basic approach is "How can I help you learn what you want to learn?"
Usually helps learners deal with content in just one way.	Usually helps learners deal with content in a variety of approaches.
Often begins and ends with a lecture approach.	Uses a lecture to get at something else, e.g., application of content to personal experience.
Rarely asks a lot of questions about learners.	Usually asks a lot of questions about learners, e.g., "What do you want to learn?"
Encourages learners to see a particular view of reality within the subject matter, e.g., "The most important thing to do after you have had a baby is to rest. Leave the baby to us."	Encourages learners to develop their own view of reality by using the subject matter and their own experiences and feelings, e.g., "How does the idea of rooming-in sound to you today?"
Sees herself/himself as completely responsible for what goes on in the learning situation.	Sees herself/himself as sharing the responsibility for the learning situation with the client.
Usually does not involve the learners in planning, presenting and evaluating the course or content.	Involves the learners in every aspect of the program's content and process.

Five Principles for Facilitating a Learner-Centred Approach

1. Set a comfortable climate for learning

The postpartum period is a time of both positive and negative stress. As a learner-centred facilitator, it is important to do whatever you can to encourage your clients to feel comfortable during this intense time. You could try sitting down so that you are all at the same eye level or standing quietly without moving while you listen carefully to what clients are saying. It is important to be patient with repeated questions, seeing them as a plea for reassurance rather than an indication of stupidity; it is also important to let people know that no matter how they feel, their feelings are legitimate. You might also pay attention to the physical comfort of the client by changing a bed position, answering questions during a light massage or assisting with feeding the baby.

Think about your work situation. How can nurses improve the learning climate in both one-on-one learning situations and in small group classes?

2. Share control of both the content and the process

The PPSP is designed so that parents can choose their own questions from a prepared list. By using this approach, they are participating in making decisions about what they want to learn. As a nurse, you may also realize that there are other things that a particular person may need to know. How could nurses make it easier for parents to learn something they should know but haven't asked about?

The PPSP is also set up so that parents will have input to the process, or how they will learn this information. In a hospital setting where schedules often dictate how much time nursing staff have and how they will respond to mothers' questions, mothers and fathers are in a very vulnerable position. How might nurses involve the parents in the process side of their education, too?

When parents are at home, they may also feel vulnerable by having a community health nurse visit them. How could a visiting nurse give parents some control over the process of the visit?

3. Build self-esteem

A mother's progress through postpartum is closely related to her own self-esteem. If she is feeling good about herself and her ability to handle the situation, then she will likely move along well and become more independent. Nurses can encourage self-esteem in all family members by confirming that their responses to the entire birthing process are legitimate and that other people have experienced similar reactions. Further practical applications of this principle involve:

- ensuring that parents understand that any mistakes they make are an important part of the learning process.
- answering the low-risk (less intimate) questions before the high-risk (more intimate) ones.
- keeping to the learning pace of the mother and father rather than the nurse's teaching pace, e.g., "Did I make that clear?" or "What other questions come to mind?"
- keeping the threat of time limits to a minimum, e.g., "I want to make sure we have enough time, so how about if I finish this first and then come back?"
- encouraging parents to express their personal opinions about a question or answer regardless of what the Staff Reference Manual (Resource Book) says.
- legitimizing parents' personal opinions while at the same time providing accurate content, e.g., "Yes, we used to think that, but in the last ten years or so, our thinking has changed and now we . . ."
- suggesting that parents share their experiences with other parents in their communities.

What other ideas do you have for how you might build self-esteem during this anxious time?

_____

_____

_____

_____

_____

4. Make sure that what the parents learn applies to their home situation

To integrate new information into the context of our own situations, it is important to be able to apply it practically in day-to-day life.

If you are a hospital nurse teaching baby baths on a table specially equipped for that purpose, then chances are that the people in your group will have a different situation at home. Some may be giving baths in a sink, others with a basin on the floor, still others in a large tub. By asking questions and learning to work within the restrictions of other people's situations, you will be

able to make the content (the theory about bathing babies) apply to their individual realities, e.g., "Now this is just the way we do it in the hospital; how will you be doing it at home?" or "Your baby doesn't mind where he/she is bathed as long as he/she isn't cold or frightened. Where will you bath your baby?"

With shortened hospital stays, many mothers leave before completing the "Taking In" phase. As a result, the role of community health nurses is significantly expanded, and they often are in contact with new mothers at the time when they are most ready to learn.

How could hospital and community health nurses work with mothers to ensure that they can apply the PPSP content to their own personal lives? Give specific examples of questions, comments or approaches you would use.

5. Encourage self-responsibility

As a postpartum mother adapts to her "New Beginnings" she will be working through a number of identifiable phases. (See Unit II). As she makes these transitions, she gradually becomes more responsible for her new status, her new baby and the new family situation.

One way to ease the move through these phases is to help the mother to feel comfortable with her present phase. Once she believes that she is "OK" and that her emotional and physical responses are within a normal range, it becomes much easier to think about taking on new tasks and responsibilities. If she does not resolve how she is feeling about the present, her progress through more advanced phases is delayed.

Imagine that you are a community nurse in a discussion with a mother who is in the "Taking Hold" phase. How might you confirm her experience and help make it fit into her own situation? Give specific examples of what you might say or do.

Imagine that you are a hospital nurse discussing circumcision with an anxious father who is holding his three-day-old son. How would you help him in taking the responsibility for this decision?

Questions and Answers

Because of the nature of the PPSP, much of the learning will take place in discussion between a nurse and a mother or father, primarily through questions and answers. As a general guide, remember the "Humanity"[2] that is the essence of learning in these situations:

- H – honesty with other people
- U – understanding of their problems
- M – mutual respect
- A – awareness of your limitations and other's
- N – negotiability
- I – identification with the feelings of others
- T – trust
- Y – "you" orientation along with "I"

Reasons for Questions Asked by Postpartum Mothers and their Families[3]

To gain practical information	"What can I do to ease these sore nipples?"
To uncover motives and gain insights	"Why did you decide to have a birthing room?"
To give information	"Did you know that I had a tear in addition to my episiotomy?"
To obtain nurse participation	"Is it OK for you to help me with the first feeding?"
To check understanding and interest	"How did I do that time?"
To start a nurse thinking about a problem	"Did you know that my wife has not slept for the last three nights?"
To reach agreement	"Do other women complain about this too?"
To return attention to a subject	"Could I just ask a couple more questions about how to do this cleansing?"
To encourage and build trust	"When did you start working with this program?"
To understand emotional tension	"How long have you been a maternity nurse?" or "Are you really busy on the ward?"

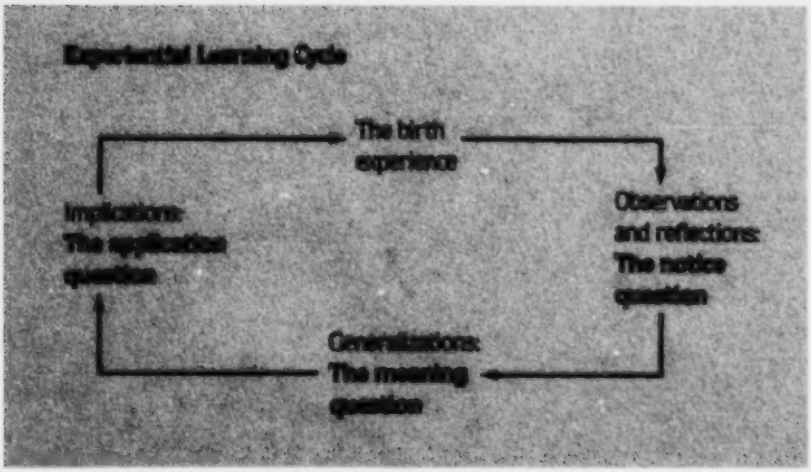
Because people have a variety of reasons for asking questions, it is important for nurses to clarify what a mother needs or wants to know before searching for a simple factual answer in the Staff Reference Manual (Resource Book).

The Experiential Learning Cycle

An experience is something you live through. As a facilitator you are working with parents as they live through the phases of the postpartum experience. You can encourage them to understand their experience in the context of their own lives by knowing how to ask the questions that will prompt them to think about what happened, what they noticed about their experience, what it means to them and how they can apply this information in their daily lives.

Many mothers complain about feeling lost or fragmented as a result of their experiences during the postpartum period. They talk about "missing pieces" of their experience and not being able to fully integrate their experience and make sense out of it all.

By understanding how the experiential learning cycle works, you can ask questions that will help mothers and other family members in dealing with their birth experience.



A client can move through this cycle very quickly in a matter of a minute or two, or quite slowly over several weeks or months. The list of questions and the Staff Reference Manual (Resource Book) both help to speed up this process.

Sample Notice Questions:
What sort of labour did you have?
How was the delivery?
What stands out in your mind most about your labour and delivery?
And then what did you notice?

Sample Meaning Questions:
How did your labour compare to what you expected?
Are you feeling like you thought you would?
So you feel different today from yesterday. Why do you suppose that is so?
Do you know other people who have felt this way?

Sample Application Questions:
What kind of changes does this new baby bring to your life?
What kind of support will you have while you work into your new role?
What do you think will be (is) most difficult about your first week back home?

Tips for Asking Questions of Clients	
Know your learner(s), including a little bit about their cultural background, the size of the family and their expectations	"Is this how your mom had you?"
Move from low-risk (less intimate) questions to high-risk (more intimate) questions	"Let's start with the easy ones."
Move from closed (single answer) questions to open (many answers) questions	"How long was your labour?"
Ask permission to ask questions	"May I ask how you decided to do it this way?"
Build a new question on the previous response	"That brings up another good question."
Focus your questions according to your learner's needs, e.g., phase of postpartum	"How do you feel about learning something new?"
Avoid ambiguous questions, ask exactly what you want to know	"Were you worried about having a Caesarean birth?"
Use common language that suits your client's level of understanding, e.g., uterus/womb	"So most of your discomfort is around your bottom?"
Don't use slanted or manipulative questions	Ask "How is your husband doing?" instead of "Your husband sure seems uneasy with the baby, doesn't he?"
Don't use threatening, leading or intimidating questions	"Surely you don't think that . . . "
Use a bridge for sensitive questions	"Many women are concerned about how they will feel making love the first time after the birth, so your question is a very common one. Is this your first baby?"

Tips for Answering Questions from Clients

Confirm that the question is a reasonable one, either verbally or non-verbally	"Good question."
If necessary, check to make sure you understood the question	"Are you asking if . . . ?"
Clarify the learner(s) purpose in asking the question	"Does this mean that the baby seems to cry too much?"
Move from low-risk answers to high-risk answers	"Let's start with the easy part."
Have one main thought	"The main point is that . . ."
Focus on giving enough information for the learner to absorb, not on telling everything now	"I can recommend a good book if you want more information."
Be prepared to say	"I don't know. But I can find out easily."
Provide an opportunity for the learners to adapt the information to their own situation. Be sure to ask them how they plan to do this	"How will you set up a changing area in here?"
Listen carefully; are you allowing those asking the questions an opportunity to create their own answers?	

Create a series of questions that would help a mother coming to terms with having a Caesarean birth when she had high expectations of a vaginal delivery.

References

1. Strachan, Dorothy Pitters. *A Handbook for Trainers of Fitness Leaders*. Ontario Ministry of Tourism and Recreation, 1982, p. 26, adapted.
2. Schneider, Donaghy, Newman. *Organizational Communication*. Toronto: McGraw-Hill Book Co., 1979, p. 69.
3. Hunsaker, Phillip and Anthony Alessandra. *The Art of Managing People*. Toronto: Prentice-Hall Inc., 1980. The inspiration for this approach came from reading "The Art of Questioning", pp. 95–119.

Further Reading

Brundage, Donald H. and Dorothy Mackeracher. *Adult Learning Principles and Their Application to Program Planning*. Ministry of Education, Ontario, 1980. Available from the Ontario Government Bookstore, 880 Bay Street, Toronto, Ontario, H7A 1L2.

Bull, Margaret and Donna Lawrence. "Mother's Use of Knowledge During the First Postpartum Weeks," in *JOGNN*, July/August, 1985.

Hunsaker, Phillip and Anthony Alessandra. *The Art of Managing People*. Toronto: Prentice-Hall, 1980.

McKay, Matthew, Martha Davis and Patrick Fanning. *Messages, The Communication Skills Book*. New Harbinger Publications, 2200 Adelaide Street, Oakland, CA 94607, 1983.

Strachan, Dorothy Pitters. *A Handbook for Trainers of Fitness Leaders*. Ontario Ministry of Tourism and Recreation, 1982. Available from the Ontario Government Bookstore, 880 Bay Street, Toronto, Ontario, M7A 1L2.

Unit IV:

Moving into Action

Beginnings are always hard; they often don't lie ready to hand . . . and what everybody wants will emerge only slowly.

Goethe

This unit helps show how to plan for making the PPSP an integral part of your maternity care program. Because each health care system (whether provincial or municipal) is unique, as is its position on maternity care and its professional history and philosophy about a family-centred approach, there is no single right way to begin this planning. Instead, some considerations and an example of how you might structure what needs to be done are provided.

To integrate the PPSP successfully into your community's health system, many people with different interests and specialized information must work together to achieve the same goals. Three steps, with specific tasks and considerations for each, are identified.

In the pages that follow, the challenges of each step are listed, followed by supplementary information and a blank "To Do" chart. The focus is on providing information so that readers can adapt these ideas to their individual situations.

Step by Step

Step one:
Initiation

Step One is to develop a thorough understanding of the program, its goals, philosophy, content and resources. Here the program is formally adopted, program materials are reviewed and committees are set up to advise and co-ordinate the entire project.

Step Two:
Implementation

In Step Two, the committees and health professionals work together to deliver the program to families. Inservice training, documentation of client learning and co-ordination of multi-agency services are included.

Step Three:
Continuation

Step Three prepares others within the system to maintain the activities that ensure the long-term success of the program. It also includes a continuous, efficient and effective evaluation process.

Step One: Initiation

Meaningful change occurs as a process, not an event.[1]

Initiation: the Challenges

- to develop a thorough understanding of the program, its resources, goals and objectives, target group, the need it is designed to fill;
- to introduce the idea of the PPSP to the appropriate individual in an agency to get things started;
- to arrange for a multi-agency meeting to ensure complete involvement of the entire home-hospital-home continuum;
- to develop an attractive and dynamic presentation of the program for professionals in your agencies, parent groups, childbirth educators, etc.;
- to assess the readiness of agencies in your health care community to implement this program, e.g., do they already have a family-centred philosophy? See the issues checklist.
- to identify key people who will be working on committees to advise and implement the program. Create terms of reference for the committees.
- to identify the Project Co-ordinator and develop a job description;
- to focus on awareness in the community-at-large regarding the PPSP and its potential impact on postpartum care, e.g., a "wellness" rather than an "illness" program and a "client" rather than a "patient" orientation;
- to create an overall implementation schedule using the form at the end of this step;
- to review the resource materials;
- to think about how to create supportive links between agencies to ensure continuity of care.

It will probably take between three and nine months to complete the initiation step, depending on the readiness of your health care community as indicated by the needs assessments done with each agency.

The next several pages contain suggestions for committee set-up, ideas about needs assessment and a description of the Project Co-ordinator's role. Keep your Step One "To Do" list in mind as you work through this section. Write down reminders and tasks to be done so that you can co-ordinate your ideas into the "To Do" list.

Structural Options: Committee Set-up

There are as many ways to set up the structure that supports this program as there are communities in which to implement it. In most cases, you will need two committees:

a) an advisory group to provide guidance and ensure appropriate interaction among professional groups and agencies;
b) a project team to be the primary working support group for each agency.

Try to use existing committees to prevent duplication of effort and to ensure continuity.

a) Advisory Committee

The Advisory Committee is responsible for:

- advising and recommending actions to implement PPSP;
- reviewing and approving program resources in light of current policies and procedures in the hospitals and health units, and recommending action or revisions where needed, e.g., change policies, adapt resources; and
- general public relations including advice and recommendation strategies to introduce the program to community physicians, to the public and to other community agencies.

Membership options for the Advisory Committee:

- hospital administration;
- nursing administration;
- hospital medical staff – representatives from obstetrics, pediatrics and family practice;
- community physicians;
- public health administration;
- community health nursing (both acute and preventive care);
- project team liaison person, e.g., Project Co-ordinator;
- social work administrator

b) Project Team

The Project Team is the primary working support group, meeting regularly during the project, responsible for:

- providing leadership for the implementation of the program;
- reviewing the program materials through each agency's representative;
- planning the orientation of hospital and health unit staff, including the phase-in of program resources;
- providing continuous feedback to hospital and health unit nurses working on the project;
- providing problem-identification and problem-solving support to the co-ordinator; and
- identifying a consulting group (once the program is implemented) to do continuous content revision and updating of materials in each agency.

The Project Co-ordinator often chairs this committee.

Membership options for the Project Team:

- maternity nursing co-ordinator or supervisor;
- community health nursing co-ordinator or supervisor;
- head nurses in each maternity area;
- social worker;
- physiotherapist;
- nutritionist/dietitian;
- pastoral care worker;
- community health nurses;
- maternity nurse clinician;
- hospital staff nurses;
- medical staff;
- inservice education people

Committee Make-up

	Agency/Department	*Representative*
Home		
Hospital		
Home		

Think about your health care system with respect to committee set-up. Which agencies or departments and their representatives do you think should be involved on committees in this program along the home-hospital-home continuum?

The pilot tests for the PPSP indicate that the best approach is to look at what others have done, know your own situation well, consider the suggestions provided in this handbook and then create a structure and committee set-up that is tailor-made for your situation. The set-ups used in the pilot tests illustrate this.

The Winnipeg pilot was unique in that it used a multi-agency approach, and its success involved co-operative efforts among five hospitals and two community health groups. The Advisory Committee in this case consisted of nursing administration and education people, with medical representatives on the project team for each agency.

For the pilot test in Sydney, Nova Scotia, the perinatal committee already in existence at St. Rita Hospital formed the advisory and project committees for the program. This was a management committee overseeing the program content and ensuring its feasibility in the Sydney area. The link between the hospital's Perinatal Unit and the Public Health Department was already well established.

In Chicoutimi, Québec, the Advisory Committee met on a weekly basis during the initiation step for planning purposes, with each committee member playing an important role with his/her staff during this step. The committee also assumed responsibility for the ongoing evaluation of comments and suggestions made by personnel, and corrected materials as necessary to meet local needs.

When you have your committee structure in place, the next task is to identify a project co-ordinator and complete a job description for that position.

c) The Project Co-ordinator

Co-ordinators' roles will vary considerably, depending on the community in which they are working. In a small hospital or community health setting, the co-ordinator may be the person who sets up and delivers the entire program, initiating the idea, co-ordinating the development of resources, teaching the inservice, monitoring and evaluating. On the other hand, a co-ordinator in a large teaching centre may have several staff members available to do these jobs.

Because the Project Co-ordinator is the person responsible for communicating and interpreting the PPSP to the health professionals who will deliver it, this person should be a member of both the advisory committee and the project team.*

This role involves:

- acting as a resource person to the staff;
- helping nurses and other professionals to understand the objectives of the project;
- transforming the objectives into concrete terms in the health care system;
- ensuring that excellent inservice programs are offered during Step Two: Implementation; and
- working with other health professionals to help them develop skills as adult educators.

* See the Project Co-ordinator's Checklist in the Appendix for a more detailed discussion of this position.

Ideally, the Project Co-ordinator should also:

- demonstrate a high degree of competence as a maternity health professional;
- have an understanding of the practice of learner-centred approaches to adult education;
- demonstrate well-developed communication skills, specifically in listening and in giving and receiving feedback;
- have superior problem-sensing and problem-solving skills; and
- be a leader who can generate support and enthusiasm in others and to be able to elicit community support.

Think about your health care system. Which agencies in your community are ready to accept and implement a program such as this one? Consider committee set-up, existing educational services, policies towards maternity issues, the introduction of other new programs, etc.

Needs Assessment

How the PPSP is implemented depends largely on a number of conditions present in the health care community it will serve. For example, the time necessary for each step in the project may be shortened if there is already a progressive attitude towards family-centred care in your system and if there are not a lot of other projects already under way in the agencies involved. By doing an assessment of where agencies are with respect to the PPSP, you can determine whether the time is right to move ahead quickly with Step Two: Implementation or whether a particular agency will need to make changes, e.g., perhaps in some of its own policies before becoming involved with the PPSP.

Agencies to be Considered for the PPSP

Agency	*Readiness (yes/no/don't know)*	*Changes needed (if any)*

Issues Checklist

The "Issues" checklist provides a way to review the status of various items in an agency so that you can determine whether the agency is ready for PPSP and what its exact needs may be.

The following items, incorporated into the PPSP, are identified as either controversial or key to successful implementation.

	In your agency/department/community/region is this item:		
	Currently practised	*Practised, needs review*	*Not practised*
1. Maternity care is implemented according to a written policy on family-centred care.			
2. Agencies share information on maternity care among themselves, e.g., nurse to nurse or administrator to administrator.			
3. Resource materials are available to share with parents and other health professionals; these materials are developed and approved in concert with other agencies.			
4. Readily accessible parent-support programs exist in the community.			
5. Readily accessible well-baby clinics exist in the community.			
6. All mothers are visited at home within two weeks of delivery.			
7. Priority is given to visits for early maternity discharges.			
8. Rooming-in is an option in the hospital.			
9. Combined nursing care is practised, i.e., the nurse caring for the mother also cares for the mother's newborn.			
10. Fathers are welcome on the postpartum unit.			
11. Teaching times are flexible, i.e., to accommodate fathers in the hospital and community.			
12. Siblings and grandparents are able/allowed to hold the newborn in the hospital.			

	In your agency/department/community/region is this item:		
	Currently practised	*Practised, needs review*	*Not practised*
13. Early, frequent feeding is supported by health care staff: a) breast feeding is initiated in the delivery area; b) babies are being fed on demand (approximately every two to three hours).			
14. Night feedings are encouraged to begin on first night.			
15. No supplements are given to healthy breast-feeding newborns (of formula, glucose water or water).			
16. No formula is given to the mother as she leaves the hospital.			
17. Temperature of the newborn is taken by axillary method; community health nurses support and encourage this method.			
18. Daily baths of newborns are done using the dry*skin method, i.e., routine use of soap in daily baths is being eliminated; this method is supported in the community.			
19. Interdisciplinary maternity team approach is used.			
20. Liaison public health nurse is available to co-ordinate community referrals.			

To Do List: Step One – Initiation

What to do	*Who to do it*

By when	*Who to consult*	*Who to inform*	*When completed*

Step Two: Implementation

Well, the hard work is done. We have the program adopted; now all you have to do is implement it.[2]

Implementation: the Challenges

- to finalize the critical path for the step-by-step implementation of the program;
- to follow through on the established work plan with energy and enthusiasm;
- to determine how written and oral communication will take place between the hospital and the community to ensure continuity;
- to arrange for inservice training for all agencies;
- to focus on adequate adult education training for nursing staff;
- to create ways to document client-learning as part of the evaluation process.

The implementation step takes about a month from start to finish. The more thorough the preparation in the initiation step, the smoother the process in this one.

Inservice Education

Inservice needs vary, depending on a number of factors such as the work experience of the participants, whether they are in a large or small hospital/community, an urban or rural setting and the relative progressiveness of the agencies involved. It is important for the project co-ordinator (or whoever does the training) to be clear about participants' expectations before the inservice sessions and to integrate those needs into the design.

The designs provided are only samples to present ideas about how to set up your own sessions. Ideally, there is an initial workshop in which participants are introduced to the program and become familiar with its resources. This is followed by further inservice training which actually uses the resources within a learner-centred approach to adult education.

Both sessions are set up for multi-agency involvement, i.e., with hospital and community health nurses learning together. The first session provides an excellent opportunity to bring in other people who would benefit from a familiarity with the program, e.g., administrators from the agencies which will be involved in its delivery.

Tip: This handbook is set up so that sections can be photocopied as handouts for inservice programs, e.g., The Three Phases of Postpartum, Theory Into Practice, the C.A.R.E. Approach and Five Principles for Facilitating a Learner-Centred Approach.

Sample Inservice Education Design Session #1

The initial inservice session serves a dual purpose: it provides an opportunity to phase in the program resources as well as an orientation for health care professionals.

To introduce the program resources, distribute copies* of the List of Questions, the Staff Reference Manual (Resource Book) and the Information Sheets to nurses and other health professionals two weeks before the inservice session in which they will be involved and ask them to review the materials. Encourage them to be candid and to offer their own ideas for how these resources might be improved.

Introductions: the Project Co-ordinator and/or Workshop Leader; workshop participants.

Brief history of the program; how this workshop fits into the larger program across Canada.

How multi-agency involvement in this workshop contributes to continuity of care.

Purpose of the PPSP, objectives, resources. How the structural set-up of communities enhances the program delivery and ensures that the resources fit into existing policies and procedures.

Review of the agenda: post it where it can be seen throughout the session.

Define the terms in family-centred maternity care so that everyone is on the same footing.

Brief history of the development of family-centred approach and what it means. Option: use the Canadian Institute of Child Health film on family-centred care.

Integrate the three phases of postpartum experience into the family-centred approach. Handouts: The Postpartum Experience and Theory Into Practice.

Discuss the resources and participants' responses to them. Describe how the committee set-up for the program will take participants' input and review it in light of current policies and procedures.

Review the C.A.R.E. approach and how it works within the PPSP. General discussion. Handout: The C.A.R.E. Approach.

Discussion: questions, concerns, suggestions. Preview of the next inservice session. Wrap up.

* Because of the cost factor, you may decide to circulate copies to groups rather than to individuals.

Sample Inservice Education Design Session #2

Start-up

Brief review from the first session.

Introduction: the Project Co-ordinator and/or Workshop Leader; workshop participants.

Brief history of the program; how this workshop fits into the larger program across Canada.

How multi-agency involvement in this workshop contributes to continuity of care.

Purpose of the PPSP, objectives, resources.

Agenda for this morning; post it where it can be seen throughout the workshop; confirm that it is appropriate.

Hand out small file cards and ask participants to write a question or concern on it. Collect the file cards halfway through the session.

Describe the objectives of the workshop, grouped according to what you would like people to know, understand, be able to do and value after they have been working with the program for six months.

Introduction to adult learning.

Ask people to think for a few minutes about who was the best teacher they ever had and why.

Elements for large group discussion: emphasize that the reasons they remember these good teachers are the principles of adult learning. Make links back to the Five Principles, explaining each principle as the opportunity arises.

Handout: Five Principles for Facilitating a Learner-Centred Approach.

Questions for discussion in small groups:

1. What needs did they have then that made that teacher best for them?
2. What needs do they have as learners now, in this workshop?
3. What needs do they think mothers and their families will have during the high-tension times of birth and postpartum?

Plenary discussion of the answers to question #3, along with suggestions for applying the adult learning principles (the five mentioned previously) to fulfill these mothers' needs.

Lecturette: A Learner-Centred Perspective, including brief comparison of traditional teaching to learner-centred facilitating.

Plenary discussion.

Break.

Theory Into Practice.

Present the theory behind asking and answering questions.

Handout: Questions and Answers. Explain how the experiential learning cycle works.

Ask each person to select two questions from the list used by parents.

Group participants in threes, with one person acting as a nurse educator, another a client, another an observer. Ask the client to read out one of her questions. The nurse educator responds using the information she has learned so far in the workshop. She and the client discuss the question for about a minute. The observer watches to see if the principles of adult learning and the guidelines to questioning are being observed. After the minute is up, the group of three discuss (with the observer leading) how they might have done it differently or whether it went well.

Then shift roles to let each person take on a new responsibility.

Each interchange should take about a minute. Each discussion following the interchange should take about three minutes. Each person should do two questions or statements, and the entire exercise should take about 6×4 or 24 minutes.

Tip: Be firm about the time limits.
Tip: Emphasize the importance of effective communication skills.

Summarize the learning from this exercise in the plenary discussion.

Return to the file cards you handed out at the beginning of the day and answer questions that have not already been handled. Make this about a 25-minute friendly discussion, a transitional period where participants can address their own specific concerns about implementing the program.

Comment on how becoming a learner-centred facilitator is a long and rewarding process, and on how it is important to jump in and make some good mistakes. "Becoming an effective facilitator means becoming more and more like yourself."

Learning from the Pilot Studies*
The reports of those involved in the pilot studies provide some useful ideas for how to enhance your own step-by-step implementation process.

Factors that facilitated implementation:

- The original concept created by St. Joseph's Hospital in Hamilton, Ontario, was practical and consistent with the philosophy of many of the agencies involved.
- Our agencies recognized the cost benefit (i.e., in time, skills and budget) of working together to create a standardized resource.
- Because they could review and revise the program resources, our staff identified with the project and felt it belonged to them, thus increasing willingness to participate.
- The program readily received agency and multi-disciplinary support and our staff acknowledged the need for a postpartum parent support program.
- The provision of an Issues Checklist for the Implementation Phase was really helpful.
- Our hospital worked with an existing patient care standards committee which helped us to establish the advisory and project committee.
- Revisions that we made to the resources did not require changes in policies and procedures in our agencies.
- Materials which did not require revision did not conflict with our policies or procedures.
- Our hospital already supported the philosophy and objectives regarding family-centred maternity care.
- Program materials were a welcome addition as a resource; they provided consistency for us and were applauded for clarity and practicality.
- We distributed the program resources in a well-organized and systematic fashion.
- Our Project Co-ordinator was well organized, available, providing ongoing assistance throughout the pilot; she changed her hours of work (from 11:00 a.m. to 7:00 p.m.) to accommodate the educational needs of staff and clients.

* The information in this section is adapted from reports submitted by the health care centres involved in the pilot studies that were part of the development of the PPSP.

Factors that impeded implementation of the program:

- Limited space, staff and educational funding.
- General visiting hours provided some need for us to juggle schedules.
- Transferring of some postpartum mothers to another unit before discharge interrupted our educational process.
- Things were complicated for us by short stays in hospital for mothers who delivered normally, as well as unanticipated early discharges.
- A prolonged "Taking-In Phase" and delayed "Taking Hold Phase" changed our projected timing about learning readiness.
- We had insufficient time for all staff to attend inservice and to become better acquainted with materials.
- We didn't have combined care philosophy in our area.
- The additional time and money required to adapt the materials delayed our implementation.
- When doctors were presented with an explanatory letter and the Resource Book, and an invitation to respond, we received very little response.
- It was hard for us to set up a team, and it took longer than we thought. The nursery staff feels that they belong to the nursery; the postnatal staff has the same sense of identification; the mother and child health staff share a similar perception. Just the fact that all staff would answer questions giving the same content was a major step forward for us.
- Although the program can theoretically be implemented in 13 weeks, in actual practice, it took us much longer.
- It was time consuming to arrange the meetings necessary to bring our staff together to work as a team.
- We had difficulty training the advisory committees; they only met once. We saw them more as a marketing tool than as being necessary to implementing the program.
- We found that if there is too great a gap between the present situation and the philosophy you are trying to implement, it is important to make some changes before going ahead, e.g., wait for an agency to update its approach before implementing the program.
- The choice of the Program Co-ordinator we found crucial to the success of the program.
- In many of our cases, the client did not know that she was supposed to take the questionnaire home and thus didn't understand that it was to be used in conjunction with the community health nurse.
- A number of our hospitals started the project on different dates which made it difficult to provide consistent and current information to community health professionals.
- The personal changes required for nurses to accept and apply the principles of adult education took longer than we anticipated.
- The Inservice component for this program is a vital element, but it took us a considerable amount of planning and a great deal of staff time. A compounding factor for many agencies was the scheduling of this program along with other agency priorities, resulting in a considerable amount of time spent at Inservice sessions.
- We were surprised at the large number of questions that clients asked; this one-to-one process took much more time than we initially anticipated.

To Think About
Which of these factors do you need to attend to in your situation and how can you prevent them from impeding you?

Factor	*Strategies*

Making Change

Implementing a new program involves change. Just as a new mother must go through a sometimes bewildering series of events in the postpartum period, so do organizations encounter difficult times as they experience change and implement new approaches. Read each of the following statements[3] and then jot down your ideas for how it might relate to the implementation of the PPSP.

Successful health care programs in the past have been those that are seen by clients and staff as: i) meeting an established need; ii) having clear goals and carefully structured means to achieve them; iii) not requiring difficult and extensive personal changes; iv) being of high quality and very practical.	
If previous innovations have failed, you will have to deal with feelings of frustration among staff, lack of support and disillusionment.	
Quality program planning is more important than the number of planners.	
Schedules with not enough time built in add significantly to the burdens of implementation.	
Central decision makers know the complexities of the initiation and adoption process; practitioners know the complexities of the implementation process.	
Administrators are more likely to support new programs that enhance the image of their organization as professional, responsive to change, efficient and up-to-date.	
Program adoption never occurs without a Project Co-ordinator who assumes the role of advocate.	
Educational change involves a certain amount of ambiguity, ambivalence and uncertainty about what the change will mean.	
Effective implementors focus on the process of clarification. People within a group are bound to see things differently, but conflict and disagreement are not only inevitable but fundamental to successful change.	
Effective change always takes a long time and is developmental in nature. Expect significant change to take a minimum of two or three years.	

To Do List: Step Two – Implementation

What to do	*Who to do it*

By when	*Who to consult*	*Who to inform*	*When completed*

Step Three: Continuation

Tomorrow and tomorrow and tomorrow...

Continuation: the Challenges

- to create support systems that will firmly root and sustain programs (e.g., committee structure, new Project Co-ordinator);
- to arrange for regular reports from the committees and the Project Co-ordinator on how the program is meeting the needs of the target groups;
- to create and install a program evaluation process within your system and to document patient learning and staff development;
- to create a strategy for updating both the program content and process to suit your community; and
- to make recommendations for improvements.

To Do List: Step Three – Continuation

What to do	*Who to do it*

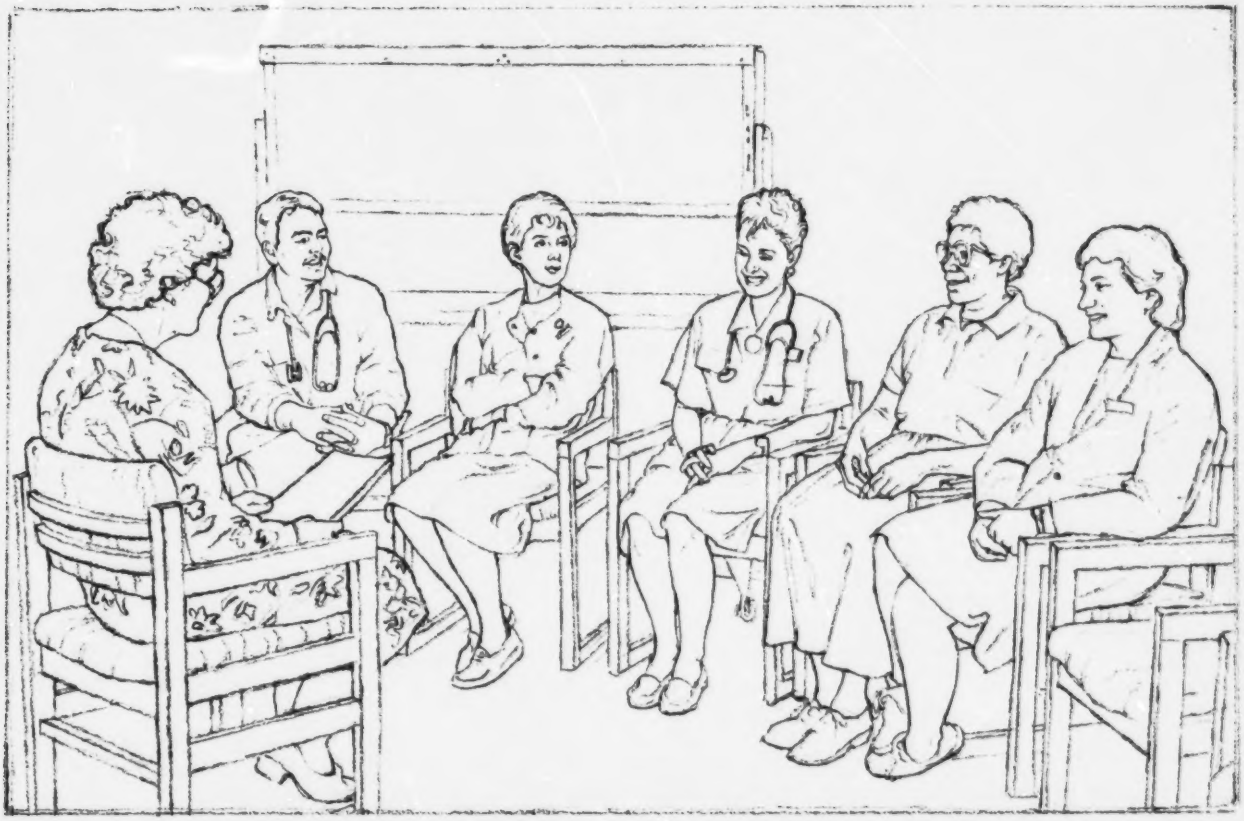
By when	*Who to consult*	*Who to inform*	*When completed*

Evaluation

A major factor in the success of a new program is evaluation that continually nourishes the program, keeping it up to date and responsive to changing needs and interests. In the PPSP, this may involve tracking what the client learns, recording what health care professionals feel about the program and monitoring any impact on the community.

Agencies currently involved in delivering the PPSP have developed evaluation tools which you may want to amend to suit your own situation. The Manitoba Postpartum Education Committee's "Record of Postpartum Patient Learning" (see Appendix) has proven successful both in recording client learning and in passing this information along from the hospital to the community health staff. In addition, the Staff Questionnaire (see Appendix) developed by the Maternal and Child Health Program in the Hamilton area may help to understand how hospital and community health nurses felt about the program.

Monitoring the impact of the program in your health community will involve a wider view that encompasses all of these forms, as well as feedback to the committees involved, comments from participating families, impressions of medical staff, results of public promotions, media response, etc. The reporting process that is developed as part of the evaluation should reflect this diversity of impact through its set-up.



Summary

Projects involving educational change, such as the PPSP, can be intensely rewarding when they are implemented by informed and sensitive individuals who understand both the program and the milieu in which it will be operating.

References

1. Fullan, Michael. *The Meaning of Educational Change*. Toronto: OISE Press, 1982.
2. Ibid, various locations throughout this book.
3. Ibid, various locations throughout this book.

Further Reading

Brager, George and Stephen Holloway. *Changing Human Service Organizations*. Politics and Practice. London, New York: The Free Press, Collier MacMillian Publishers, 1979.

Casella, Cono. *Training Exercises to Improve Interpersonal Relations in Health Care Organizations*. Panel Publishers.

Egan, Gerard. *Change Agent Skills in Helping and Human Service Settings*. California: Brooks/Cole Publishing Co., 1985.

Fullan, Michael. *The Meaning of Educational Change*. Toronto: OISE Press, 252 Bloor Street West, Toronto, Ontario, MSS 1V6, 1982.

Harvard Business Review. "Leadership: Parts I, II, III." A collection of pertinent articles about leaders in organizations and how they can influence positive attitudes towards change and innovation. Available from *Harvard Business Review*, Reprint Department, Soldiers Field, Boston, MS 02163. Tel. (617) 495–6737.

Morris, L.L. and C.T. Fitz-Gibbon. *Program Evaluation Kit*;
Evaluator's Handbook;
How to deal with goals and objectives;
How to design a program evaluation;
How to measure program implementation;
How to measure attitudes;
How to calculate statistics;
How to present an evaluation report
Beverly Hills: Sage Publications, 1978.

Robinson, Geoffrey C. and Heather F. Clarke. "Implementing Change." In *The Hospital Care of Children*. New York: Oxford University Press, 1980, pp. 243–262.

Appendices

1. Project Co-ordinator's Checklist

In setting objectives for how to approach the program, think about the following list where objectives are grouped according to what you, as Project Co-ordinator, need to know, understand, be able to do and value in order to implement the PPSP successfully. In the space next to each item, rate on a scale of (Low) 1 2 3 4 5 (High) how well you think you can fulfill each of these objectives. This will give you a clearer idea of what to work on to carry out your role in the project.

Tip: You and your agency are likely doing most of these things to some extent now. Don't let the list intimidate you!
Tip: Each community will have different needs and expectations of the project co-ordinator.

As the Project Co-ordinator, *I know:*

____ the program content, its goals and objectives;
____ the theoretical basis of a family-centred approach to the postpartum period;
____ technical nursing skills related to maternity nursing;
____ the structure of the health care system in our community and province;
____ the basic theory about a learner-centred approach to adult education.

As the Project Co-ordinator, *I understand:*

____ the complexity and uniqueness of each family's postpartum experience;
____ how the PPSP objectives and resources fit the needs of our health care community;
____ how the PPSP can provide consistent, high-quality information to families;
____ how a particular health care system or individual can support or resist the implementation of new programs;
____ how to get things done in a positive and constructive way within our health care system;
____ basic principles of educational change in organizations.

As the Project Co-ordinator, *I am able to:*

____ work with committees to get the program adopted in our health care system;
____ identify where and how to get assistance during the various phases of implementation;
____ get the support of senior administration in the hospitals and agencies involved;
____ establish credibility with maternity staff and community health personnel;
____ demonstrate a high degree of competence as a maternity nurse or a community health nurse;
____ communicate clearly the program's objectives, needs and projected results, both on a one-to-one basis and in more formal presentations;
____ manage efficient and effective meetings;
____ conduct inservice sessions with nursing staff;
____ have problem-sensing and problem-identification skills;
____ generate genuine support for the program in the entire health care community.

As a Project Co-ordinator, *I value:*

____ a family-centred approach to maternity care;
____ a learner-centred approach to education;
____ effective teamwork among a variety of agencies and individuals in health care as the appropriate method for continuity in postpartum support programs.

To Think About

Where are your strengths in the list?

How can you capitalize on these strengths to help implement this program?

Where do you feel least competent in the list?

What can you do to improve in these areas?

Area	*To do*

2. Manitoba Health Forms

Maternal Nursing Database

PRESENT PREGNANCY

First language _____

Second language interpreter _____

"Presenting Problem _____

Previous Admissions/Problems this Pregnancy

Bleeding _____ 1st Trimester

_____ 2nd _____ 3rd

Risk score ☐☐

Prenatal Care Yes ☐ No ☐

G _____ P _____ EDC ☐☐☐ WKS _____
day mo yr

LNMP ☐☐☐ Reg ☐ Irreg ☐
day mo yr

Ultrasound No ☐ Yes ☐

EDC by Ultrasound ☐☐☐
day mo yr

Doctor's Office ☐☐☐ FAU ☐☐☐
day mo yr day mo yr

Rh Last WinRho Inj. ☐☐☐
day mo yr

Previous blood transfusions No ☐
Yes ☐ ☐☐☐
day mo yr

Prenatal Classes: Yes ☐ No ☐

Breastfeeding: Yes ☐ No ☐ Undecided ☐

Previous Experience Yes ☐ No ☐

Exposures

Smoking _____ packs/day

Alcohol (amount) _____

Other drugs _____

Communicable diseases _____

Allergies ☐ None Known

Food _____

Drug _____

Other _____

Type of reaction _____

Surgical HX _____

HISTORY OF PREVIOUS PREGNANCIES

No.	Year	Sex	Gest. Age (Wks.)	Birth Weight	Dur. of Labour	Place of Birth	**Comments:** re Pregnancy, Type of Delivery, Anomaly, Perinatal Death, etc.

REVIEW OF SYSTEMS

Respiratory ☐ No difficulty

Neurological ☐ No difficulty

Seizure disorder _____

Migraines _____

Musculo-Skeletal ☐ No difficulty

Pre-gravid weight _____

Present weight _____ Height _____

Vision/Hearing ☐ No difficulty

Glasses ☐ Contacts ☐ Hearing aid ☐

Skin ☐ No difficulty

Cardiovascular ☐ No difficulty

Ess. hypertension _____

PIH _____ Edema _____

Heart disease _____

Varicosities _____ Hemmorrhoids _____

Gastro-Intestinal ☐ No difficulty

Dentures _____

Dietary restrictions _____

Constipation _____ Diarrhea _____

Jaundice _____ Hepatitis B _____

Genito-Urinary ☐ No difficulty

UTI _____ Kidney disorders _____

Vag. discharge _____ STD _____

Endocrine ☐ No difficulty

Diabetes _____

Thyroid disorder _____

PSYCHOSOCIAL ASSESSMENT

Present emotional status _____

Support person _____

Initial response to this pregnancy _____

Planned pregnancy Yes ☐ No ☐

Type of contraception _____

Hx of postpartum depression _____

S M W Sep. Div. C.L.

Keeping baby: Yes ☐ No ☐

Infant's physician _____

No. of children at home _____

Child care _____

Occupation _____

Returning to work: Yes ☐ No ☐

Economic concerns: Yes ☐ No ☐

Recent family stress _____

Referral to social worker needed:

Yes ☐ No ☐ To be reassessed ☐

Involved with: _____

Name of social worker _____

City welfare ☐ Prov. welfare ☐

Treaty # _____

COMMENTS

Date reviewed _____

Signature _____

MG-326 ORIGINAL - WHITE COPY — To Mother's Chart YELLOW COPY — To Infant Chart October, 1988

Newborn Nursing Database

Date of Birth	Time of Birth	APGAR 1 Min ☐☐ 5 Min ☐☐	Void Yes ☐ No ☐	Meconium Yes ☐ No ☐
Sex	Identiband #	Checked By 1) 2)		

Refer to Resuscitation Record ☐

ADMISSION TO NURSERY

Date	Time	Birth Wt.	Admission Wt.	Temp.	Apex	Resp.	B.P.

Head Circum.	Crown Rump	Crown Heel	Abd. Girth	Gestational Age Weeks	Gestational Age Assessment	Percentile	Unit Glucose and Method

GENERAL APPEARANCE

Symmetry _____

Activity _____

Posture _____

Cry _____

SKIN

(vernix, lanugo, desquamation, other)

Color _____

Turgor _____

Other _____

HEAD AND NECK

(eyes, ears, palate, neck, fontanel, caput)

CHEST

Breast Tissue _____

Air Entry _____

Resp. Character _____

Cardiac _____

Clavicles _____

ABDOMEN

Shape _____

Condition of Cord _____

Other _____

GENITALIA

Anus Patent Yes ☐ No ☐

EXTREMITIES

Hips _____

Other _____

BACK

Spine-Intact ☐ Interrupted ☐

REFLEXES

Tone _____

Moro _____

Grasp _____

Root _____

Suck _____

NUTRITION

Date	Time	Medication	Signature	Date	Time	Medication	Signature

SUMMARY

Physician

Dr. _____ Present at delivery ☐ or Notified by _____ on _____ at _____

Mother's Room #

MG-328 ORIGINAL - WHITE COPY — To Newborn Chart YELLOW COPY — To Mother's Chart October, 1988

Record of Post Partum Patient Learning

HISTORY

Experience with newborns: Yes ☐ No ☐

Ages of other children: _____

Special factors: _____

Area of Learning	Date of Teaching Initials of Teacher	Key	Date Learning Assessed Initials of Assessor
MY BODY — GENERAL			
Exercise			
Diet			
Rest			
Medications			
MY BODY — BREASTS			
Engorgement			
Nipple Care			
Expression			
MY BODY — PERINEUM			
Pericare: Hospital			
Home			
Sitz bath			
Lochia			
Involution			
Afterpains			
CESAREAN BIRTH			
Pre-op preparation			
Comfort/Positions			
PARENTHOOD			
Relations: Infant			
Partner			
Family and friends			
Family planning			
Resuming intercourse			
Postpartum blues			
Return to work			

Area of Learning	Date of Teaching Initials of Teacher	Key	Date Learning Assessed Initials of Assessor
MY BABY — FEEDING			
Production			
Positioning			
Frequency/Duration			
Burping			
Formula/Propping			
Weaning			
Solid Foods			
Breast Milk — Collection, Storage and Transportation			
BABY CARE			
Bath: Cord care			
Stools/diapering			
Jaundice			
PKU Follow-up			
Immunization			
Return appointment			
Car seats			
Circumcision			
Rashes			
Temp./Sick baby			
Positioning			
BABY AT HOME			
Development			
Siblings			

KEY TO ASSESSMENT OF LEARNING

U = Understanding indicated by verbal response

T = Task performed safely

R = Repeat, re-demonstrate, remind

C = Needs confidence building

IPN = Integrated Progress Notes

NN = Nurses Notes

PHN REFERRAL:

☐ Mailed

☐ Phoned

☐ Public Health Nurse Coordinator

RETURN APPOINTMENTS

Mother: ___ day ___ mo. ___ yr

Baby: ___ day ___ mo. ___ yr

Initials	Signature and Classification	Initials	Signature and Classification

Guidelines for Inter-agency Referral Forms

Objectives:

1. To summarize the client's physical, emotional and social history and current health status.
2. To provide information on family interaction and support systems.
3. To facilitate communication between the hospital staff and the public health nurse and between public health offices or jurisdictions.
4. To facilitate interdisciplinary and inter-agency communication.
5. To provide the public health nurse with the core data needed to develop a plan of care for the new and growing family.
6. To determine the efficiency of communication of referral information.
7. To identify trends and patterns in care delivery to support program planning.

Postpartum Referral Form

Manitoba Health

Hosp. No. | Hospital Name | MHSC Reg. No. | Admission Day Mo Yr | Region | Office | Region Code

Surname | Given Name | Date of Birth Day Mo Yr | Age | Previous Surname(s)

Permanent Home Address R.R. Group Box and or Street and Number City, Town, Village Municipality | Postal Code | Telephone No.

Husband / Significant Other | Marital Status S M W Sep. Div. C.L.

Nearest Relative or Friend - Name & Address | Telephone No.

Temporary Address | Telephone No. | Length of Stay | Region / Office if Different

MOTHER

File No.

Antepartum: Gravida Para

Mother's Education: ☐ Primary ☐ Secondary ☐ Post Secondary

Prenatal Care: ☐ Yes ☐ No (comment)

Prenatal Classes with this Pregnancy: ☐ Yes ☐ No (comments)

Location: ☐ Community Health ☐ Hospital ☐ Private

Smokes: ☐ No ☐ Yes

Complications: ☐ No ☐ Yes

Labor: ☐ Spontaneous Onset ☐ Induction ☐ Augmentation ☐ N/L

Birth: Date Day Mo Yr Time hrs.

☐ **Vaginal**
- ☐ Spontaneous
- ☐ Intact Perineum
- ☐ Cephalic
- ☐ Forceps
- ☐ Episiotomy
- ☐ Emergency
- ☐ Breech
- ☐ Vacuum
- ☐ Laceration

☐ **Cesarean**
- ☐ Elective

Status of Infant: ☐ Live ☐ Stillbirth

Complications: ☐ No ☐ Yes

Postpartum: RhIG ☐ No ☐ Yes Day Mo Yr

Complications: ☐ No ☐ Yes

INFANT

File No.

Given Name

☐ Female ☐ Male ☐ Single ☐ Multiple

Gestational Age: Dates wks Assessment wks Percentile Apgar 1 5

Weight: Birth g Head Cir. cm

Discharge g Length cm

Feeding: Type ☐ Breast Milk ☐ Formula (specify) ☐ Both

Mode ☐ Breast ☐ Bottle ☐ Both ☐ Other (specify)

Metabolic Screening

Blood: ☐ Done ☐ To be done / repeated after discharge

Immunization: BCG ☐ No ☐ Yes Date Day Mo Yr

HBV ☐ No ☐ Yes Date Day Mo Yr

Complications: ☐ No ☐ Yes

Discharge: Home with mother: ☐ Yes ☐ No If No . . .

☐ Neonatal death Day Mo Yr ☐ Remaining in hospital

☐ Placement ☐ Transfer to

Mother's Physician

Infant's Physician

Nursing Impressions

Discharge Date Day Mo Yr Time hrs

Hospital Nurse Contact (print name) Phone

Involved Agency (print name) Phone

PHN Contact in Hospital ☐ No ☐ Yes

(print name)

Referral to Field PHN: Phoned ☐ No ☐ Yes Date Day Mo Yr

Mailed Date Day Mo Yr

Received by: Office Day Mo Yr

PHN Day Mo Yr

PHN Contact: ☐ Yes Day Mo Yr ☐ No (State Reason)

Initiated By: ☐ Client ☐ PHN

Client's Perception of Length of Hospital Stay: ☐ Just Right ☐ Too Long ☐ Too Short

Follow-Up: ☐ No ☐ Yes, If Yes . . . ☐ Short Term ☐ Long Term ☐ Phone ☐ Home ☐ Other

Immunization: ☐ CHC ☐ Physician ☐ Undecided ☐ Refusal to Immunize

Referral: ☐ No ☐ Yes Name (Print)

Section A Postpartum Referral Form
To be completed on *all* mothers and their infants of 20 weeks or more gestation.

Data required	*Instructions*	*Source*
• Hospital No. • Hospital name	• Specify – MHSC Designated Number. • Specify name.	Back of Referral Form
• MHSC Reg. number	Enter MHSC number.	• Record
• Admission date	Enter day, month and year of current hospital admission. Enter 2-digit no., e.g., for March 1, 1987 enter 01,03,87	• Record
• Region	Specify region and office of residence: • Region of Manitoba Health (Norman, Eastman, Westman, Central, Parklands, Interlake, Thompson, Winnipeg South, Winnipeg West-Central, Winnipeg North) • City Health (City of Winnipeg Health Department) • Federal (Medical Services) • Name of Province (if out-of-province)	Directory of Public Health Nursing Offices
• Office • Region code	• Specify office within the region. • Enter 5-digit number.	
• Surname • Given name	Specify mother's name.	• Record • Client
• Mother's birth date • Age	• Enter day, month, and year of birth. • Enter age.	• Record
Previous surname(s)	Specify any previous name used by client (including maiden name).	• Record • Client
• Permanent home address • Postal code • Telephone number	Specify permanent home address, postal code and telephone number. *Attention:* This may differ from hospital admission record.	• Client
Husband/significant other	Specify name of husband or other significant support person (sharing same residence). If surname is same as client's, enter given name only. If different, enter surname and given name. State relationship to client.	• Record • Client
Marital status	Circle appropriate category to indicate *present* status.	• Record • Client
Nearest relative or friend	Specify name, address and phone number if other than husband/ significant other above.	• Record • Client
• Temporary address • Telephone number • Length of stay • Region/office if different	Completed when client will be staying at an address other than the permanent home address after discharge. Include the length of time client anticipates remaining there.	• Client
File No.	*For office use only – Leave blank*	

Mother

Data required	*Instructions*	*Source*
Antepartum:		
Gravida para	Specify using numerical figures and *including present birth*, ie., second pregnancy and delivery would be recorded as G_2 P_2.	• Delivery record
Mother's education	Check one box to indicate last *completed* level of education. (Primary = up to and including Gr. 8; Secondary = completed Gr. 12; Post-secondary = University, Community College, diploma programs)	• Client
Prenatal care	• Check "Yes" only if client made 3 or more prenatal visits. • If "No" give explanation.	• Prenatal form • Client
• Prenatal classes	• Check "Yes" if registered for prenatal classes with this pregnancy. • If "No" state reason, eg., none available, no interest, inaccessible.	• Maternal database
• Location	Check appropriate box. • Community Health, taught by public health nurses. • Hospital, taught by hospital staff. • Private, taught by private organizations or individuals, sometimes in hospital settings.	
Smokes	Check appropriate box.	• Maternal database
Complications	Check appropriate box. If "Yes" specify the nature of the physical and/or psychosocial complication (e.g., P1H, APH, alcohol ingestion, husband left).	• Maternal database
Labor record	Check appropriate box(es).	• Delivery
Birth: • Date • Time	 • Specify date. • Specify time in hours.	 • Delivery Record
Birth information	Check appropriate box to indicate type of delivery, i.e. vaginal or Caesarean. Check other boxes as appropriate.	• Delivery Record
Status of infant	Check appropriate box.	• Delivery Record
Complications	Check box to indicate complications. If "Yes" specify the nature of the physical and/or psychosocial labour complication.	• Delivery Record
Postpartum:		
RhIG (WinRho)	Check appropriate box – if "Yes" specify date given.	• Record
Complications	Check appropriate box. If "Yes" specify the nature of the physical and/or psychosocial complication (e.g., PPH, infection, STD, emotional disturbance, etc.).	• Record • Nurse
File No.	*For office use only – Leave blank*	*Note:* Complete all sections if infant is discharged with mother. If infant *not* discharged with mother complete only the ** sections below.

Infant

Data required	*Instructions*	*Source*
Given name **	• Specify given name if available. • Indicate infant's surname if different from mother's.	• Mother
Sex **	Check appropriate box.	• Record
Single/multiple **	Check appropriate box. If multiple, specify twins or triplets. *Attention:* If multiple, complete a postpartum referral form on each infant.	• Delivery record
Gestational age: ** • Dates • Assessment * • Percentile *	• Specify G.A. in weeks calculated from LNMP. • Specify G.A. in weeks according to IUG parameters and Dubowitz. • Specify percentile (assessed G.A. vs. weight) if available. * *Optional*	• Delivery record • Newborn database
Apgar	Specify Apgar scores at 1 and 5 min.	• Delivery record • Newborn database
Weight: • Birth ** • Discharge	Specify weight in grams.	• Delivery record • Hospital record
• Head circumference • Length	Specify in cm.	• Newborn database
Feeding ** Type: • Breast milk • Formula • Both* Mode: • Breast • Bottle • Both* • Other	• Indicate *type* of (infant) feeding on discharge. If "formula" specify. • Indicate *method* of infant feeding on discharge. If "other" specify. * If supplemented (formula or glucose) check "both" under mode *and* type.	• Record • Nurse
Metabolic screening: Blood	Check off if done or if to be done/repeated after discharge. * *Note:* Should be collected by 7 days of age.	• Record
Immunization: • BCG • HBV	Check as appropriate giving date administered if done in hospital.	• Record
Complications **	Check appropriate box. If "Yes" specify the nature of the physical and/or psychosocial complication.	• Neonatal Database
Discharged home with mother **	Check appropriate box. If "No" check appropriate box. When applicable, state where infant is transferred. If "neonatal death" state date.	• Record • Nurse
• Mother's physician • Infant's physician	State mother's and infant's primary physician after discharge.	• Record • Client

Infant

Data required	*Instructions*	*Source*
Nursing impressions	• Include pertinent data that would be helpful to the PHN on initial contact (e.g., bonding, competence, tubal ligation, etc.). • Identify potential problems anticipated on discharge regarding mother's and infant's physical and/or psychosocial status.	• Nurse • Record
Discharge: • Date • Time	Enter day, month, and year as well as time of discharge in hours.	• Nurse • Record
• Hospital nurse contact • Involved agency	*Print* name of nurse/involved agency and telephone number(s). Include name of worker if available.	• Nurse • Record
PHN contact in hospital	• Check "Yes", only if PHN involved in planning *prior to* discharge. • PHN involved to specify name.	• Nurse • PHN
Referral to field PHN	• Check box to indicate if referral phoned to PHN. If "Yes" enter date. • Specify day, month, and year referral form was sent from hospital.	• Nurse
Forward complete form to Public Health Office *Next section to be completed by Public Health Office/Nurse*		
Date Received by: • Office • PHN	Specify day, month, and year referral received by: • Office • PHN	• PHN
• PHN contact • Initiated by	Check box to indicate if mother has been contacted. (Phone or Visit) If "Yes" indicate date, and by whom initiated. If "No" state reason.	• PHN
Client's perception of length of hospital stay	Assess at time of PHN contact. Check appropriate box. Question: "Would you describe the length of your hospital stay as being 'just right', 'too long' or 'too short'?"	• PHN
Follow-up	Check "No" if no contact beyond initial PHN contact and assessment is required. Check "Yes" if further contact is required. Indicate mode and duration of contact. If follow-up is required but not possible check "other" and state reason, e.g., client moved, client refusal, other workload priorities, etc.	• PHN
Immunization	Check appropriate box to indicate where or if parent intends to obtain immunization.	• PHN
Referral	• Check appropriate box to indicate if referral made. • Specify referral individual/group/agency.	• PHN
Name	Print PHN name	• PHN

White copy is to be forwarded to Maternal & Child Health Directorate, 2nd Floor, 800 Portage Avenue, Winnipeg, R3G 0N4.
Yellow copy is to be retained as the Database in the Client's file.

Infant Referral Form

Manitoba Health

Hosp. No.	Hospital Name	MHSC Reg. No.	Admission Day Mo Yr	Region	Office	Region Code

Surname	Given Name	Date of Birth Day Mo Yr	Sex M F	Previous Surname(s)

Permanent Home Address R.R. Group Box and or Street and Number City, Town, Village, Municipality	Postal Code	Telephone No.

Parent / Guardian (Full Name)

Temporary Address	Telephone No.	Length of Stay	Region / Office if Different

File No. | Medical Record No.

DISCHARGE SUMMARY

BIRTH: ☐ 1 Single ☐ 2 Multiple _____ Weight ____ g

Dates Assessment Percentile

Gestational Age: ____ wks ____ wks ____

Metabolic Screening

Blood ☐ 1 Done ☐ 2 To be done / repeated after discharge Day Mo Yr

Urine ☐ 1 Done ☐ 2 To be done / repeated after discharge Day Mo Yr

Immunization Done in Hospital

			Date Day Mo Yr
BCG	☐ No	☐ Yes	
HBV	☐ No	☐ Yes	
DPT / Polio	☐ No	☐ Yes	

Other _____

Status: ☐ 1 Live ☐ 2 Deceased Day Mo Yr

Discharged to ☐ 1 Home ☐ 2 Placement _____

☐ 3 Community Hospital _____

Discharge: Weight ____ g Length ____ cm

Head Circ ____ cm

Physician (after discharge) _____

FEEDING

Type ☐ 1 Breast Milk ☐ 2 Formula _____ (specify) ☐ 3 Both

Mode ☐ 1 Breast ☐ 2 Bottle ☐ 3 Both ☐ 4 Other _____ (specify)

Discharge Medications ☐ No ☐ Yes _____ (specify)

Reason for Hospital Stay: ☐ 1 Congenital Anomalies ☐ 2 Cardiac ☐ 3 Small for GA ☐ 4 Prematurity ☐ 5 Respiratory ☐ 6 Hyperbilirubinemia _____ ☐ 7 Other _____

Parental Involvement _____

Family Supports _____

Follow-up Appointments ☐ No ☐ Yes 1) Type 1 _____ Day Mo Yr 2) Type 2 _____ Day Mo Yr

3) Type 3 _____ Day Mo Yr 4) Type 4 _____ Day Mo Yr

Nursing Impressions _____

Discharge Date Day Mo Yr

Hospital Nurse Contact _____ (print name) Phone

Social Worker Contact _____ (print name) Phone

PHN Referral Discussed with Family ☐ No ☐ Yes Date Day Mo Yr

PHN Contact in Hospital ☐ No ☐ Yes

Referral to Field PHN Phoned ☐ No ☐ Yes Date Day Mo Yr

Mailed Date Day Mo Yr

Received by: Office Day Mo Yr

PHN Day Mo Yr

_____ (print name)

PHN Contact: ☐ Yes Day Mo Yr ☐ No _____ (state reason)

Initiated By: ☐ 1 Parent ☐ 2 PHN

Follow-up: ☐ No ☐ Yes. If Yes, ☐ 1 Short Term ☐ 2 Long Term ☐ 1 Phone ☐ 2 Home ☐ 3 Other _____

Immunization by: ☐ 1 CHC ☐ 2 Physician ☐ 3 Undecided ☐ 4 Refusal to Immunize

Referral: ☐ 1 No ☐ 2 Yes _____

Comments: _____

Name _____ (Print)

MG-13958 (Rev. 87) WHITE COPY — Maternal and Child Health, 4th Floor, 831 Portage Ave., Winnipeg, MB R3G 0N6 YELLOW COPY — Public Health Chart PINK COPY — Hospital

Section B Infant Referral Form
To be completed on all infants *not* discharged with their mother.

Data required	*Instructions*	*Source*
• Hospital No. • Hospital name	• Specify designated MHSC number. • Specify name.	Back of Referral Form
MHSC Reg. No.	Enter MHSC number.	• Record
Admission date	Enter day, month and year of current admission to this hospital Enter 2-digit number, e.g., for March 1, 1987 enter 01, 03, 87.	• Record
• Region	Specify region and office of residence: • Region of Manitoba Health (Norman, Eastman, Westman, Central, Parklands, Interlake, Thompson, Winnipeg South, Winnipeg North, Winnipeg West-Central) • City Health (City of Winnipeg Health Department) • Federal (Medical Services) • Name of Province (if out-of-province)	Directory of Public Health Nursing Offices
• Office	• Specify office within each region.	
• Region code	• Enter 5-digit number.	
• Surname (child's) • Given name (child's)	Specify given name if available.	• Record • Parent
Date of birth	Enter day, month and year of birth in numbers.	• Record
Sex	Circle appropriate letter to designate sex of the infant.	• Record • Observation
Previous surname(s)	If current name different than original admitting name, specify the original name.	• Record • Parent
• Permanent home address • Postal code • Telephone No.	Specify home address, postal code and telephone number where the parent/guardian may be reached after the infant's discharge (may differ from hospital admission form information).	• Parent/guardian
Parent/guardian (full name)	State name of legal guardian(s). State both parents' names if different.	• Record • Parent/guardian
• Temporary address • Telephone number • Length of stay • Region/district if different	Complete when infant will be staying at an address *other than* the permanent home address after discharge. The length of time it is anticipated the infant will be at this address should be indicated.	• Parent/guardian
Medical Record #	Specify hospital medical record number.	• Record
File No.	*For office use only – Leave blank*	

Discharge Summary

Data required	*Instructions*	*Source*
Birth: • Single • Multiple	Check appropriate box. If multiple, specify type twins or triplets; fill out separate form for each infant. Note if other infant is deceased.	• Delivery Record
Birth weight	Specify infant's birth weight in grams.	• Delivery Record • Newborn database
Gestational age: • Dates • Assessment* • Percentile*	• Specify G.A. in weeks calculated from LNMP. • Specify G.A. in weeks according to IUG parameters and Dubowitz. • Specify percentile (assessed G.A. vs. Weight) if available. * *Optional*	• Delivery Record • Newborn database • Physician's newborn assessment
Metabolic screening: • Blood • Urine	Check off if done. If "to be done/repeated after discharge" check off and *indicate date required.*	• Record
Immunizations done in hospital	Check off as appropriate, giving date administered if done in hospital.	• Record
Other	Specify any other screening or immunizations done in hospital or required to be done after discharge.	• Record
Status: • Live • Deceased	Check appropriate box. If "deceased" enter date.	• Nurse • Record
Discharged to: • Home • Placement • Community hospital	• If "placed" specify agency. • If returned to "community hospital" specify hospital.	• Record • Parents
Discharge: • Weight • Length • Head circ.	• Specify discharge weight in grams. • Specify discharge length and head circ. in cm.	• Record
Physician (after discharge)	State name of infant's primary physician after discharge.	• Record • Parent/guardian

Data required	*Instructions*	*Source*
Feeding Type: • Breast milk • Formula • Both*	• Indicate *type* of infant feeding on discharge. If "formula" specify. * If supplemented (formula or glucose) check "both" under mode and type.	• Record • Nurse
Mode: • Breast • Bottle • Both* • Other	• Indicate *method* of infant feeding on discharge. If "other" specify.	• Record • Nurse
Discharge medications	Check appropriate box. State *physician-ordered* medications for use on discharge. Include name of medication, route, frequency and any special instruction.	• Record
Reason(s) for hospital stay	Check off appropriate box to indicate *primary* reasons for extended hospital stay. If "Hyperbilirubinemia" enter /uMol/L that necessitated hospital stay. If "other" specify.	• Record
Parental involvement	Indicate parental interaction with infant with regards to visits, care given, etc. Comment on both positive and negative involvement.	• Record • Primary nurse
Family supports	Indicate help available or planned to be available to parent(s) in community, i.e., extended family, friends, homemaker, etc.	• Record • Primary nurse
Follow-up appointments	Check "Yes" if any follow-up appointments, e.g., eye specialist, hearing, developmental, out-patient clinic, genetic follow-up, etc. For each state type and date, if available.	• Record
Nursing impressions	Include pertinent data that would be helpful to the PHN on her initial visit. Expand on any potential problems anticipated on discharge, i.e., infant's physical status, mother's caregiving ability, feeding problems, etc.	• Nurse • Record
Discharge date	Enter discharge date.	• Record
Hospital nurse contact	*Print* name of nurse to be contacted and phone number of ward where she can be reached.	• Nurse
Social worker contact	*Print* name of hospital social worker involved and office phone number.	• Record
PHN referral discussed with family	Check off appropriate box to indicate whether this referral was discussed with the family. If "Yes" specify date.	• Nurse
PHN contact in hospital	• Check "Yes" only if PHN involved in planning prior to discharge. • PHN involved to specify name.	

Data required	*Instructions*	*Source*
Referral to field PHN	• Check appropriate box to indicate if referral phoned to PHN. If "Yes" enter date. • Specify day, month and year (referral) form was sent from hospital).	• Nurse
Forward complete form to Public Health Office *Next section to be completed by Public Health Office/Nurse*		
Date received by: • Office • PHN	Specify day, month and year referral received by: • Office • PHN	• Clerk • PHN
PHN contact	• Check box to indicate if mother has been contacted (phone or visit). • If "Yes" indicate date and whom initiated by. If "No" state reason.	• PHN
Follow-up	Check "No" if no contact beyond initial PHN contact and assessment is required. Check "Yes" if on-going contact is required. State mode and duration of anticipated contact. If follow-up is required but not possible check "Other" and state reason, e.g., client moved, client refusal, other workload priorities, etc.	• PHN
Immunization	Check appropriate box to indicate where or if parent intends to obtain immunization.	
Referral	Check appropriate box to indicate if referral made. Specify referral individual/group/agency.	• PHN
Comments	Include summary statements re status of baby and/or family on contact. Include specific problems identified or resolution of problems identified in hospital. Print name of PHN making contact.	

White copy is to be forwarded to Maternal & Child Health Directorate, 2nd Floor, 800 Portage Avenue, Winnipeg, R3G 0N4.
Yellow copy is to be retained as the Database in the client's file.
Pink copy is to be forwarded to the referring hospital.

3. Evaluation: Sample Staff Questionnaire

Staff Questionnaire

For each statement, please indicate if you strongly agree, agree, are uncertain, disagree or disagree strongly.

As a result of my involvement with the PPSP:

	Strongly agree	*Agree*	*Uncertain*	*Disagree*	*Disagree strongly*
1. I have learned new material.					
2. I feel overwhelmed.					
3. I feel more confident teaching patients individually.					
4. I feel more confident teaching patients in small groups.					
5. I do more teaching.					
6. I do not have time to teach.					
7. I know the areas for which I need more information or practice.					
8. I am more likely to seek out material to update my knowledge.					
9. I use resources to support my teaching.					
10. My attitudes and skills have not changed at all.					
11. I am more likely to collaborate with nurses on other units, e.g., premature nursery.					
12. I feel I am more aware about what my colleagues do.					
13. The list of questions ("Help Us to Help You") does help parents to ask questions.					
14. The Staff Reference Manual provides a useful guideline for my teaching.					
15. Parents find the information sheets helpful.					
16. I disagree with the content of some of the resources.					

	Strongly agree	Agree	Uncertain	Disagree	Disagree strongly
17. I'm not sure what the content is in some of the resources.					
18. I resented the Inservice sessions.					
19. It's not worth my time and effort to use the implementation phase.					
20. We did not receive enough support during the implementation phase.					
21. The PPSP would be worthwhile in other hospitals.					
22. Newborns in hospital should be fed either breast milk or formula every four hours.					
23. Newborns (who will be breast-fed) should be put to their mother's breast soon after delivery.					
24. Community health nurses provide important teaching to multiparas.					
25. New mothers (day one, day two) are not able to learn.					
26. The patient stay is too short to bring about any real learning for mothers.					
27. Mothers are given different information (to same question) from other nurses on the unit.					
28. Doctors' information is confusing to new mothers.					
29. Rectal temperatures should be taken daily during a newborn's stay in hospital.					

	Strongly agree	Agree	Uncertain	Disagree	Disagree strongly
30. I do not need to improve my teaching skills.					
31. It's not safe to allow grandparents and siblings to hold the newborn during the hospital stay.					
32. Teaching is an important part of my job.					
33. Bathing babies with soap is a normal hospital procedure.					
34. Encouraging frequent feeding (every two hours) will cause sore nipples.					
35. It is the doctor's responsibility to teach about conditions such as jaundice.					
36. Breast-fed newborns need water while in hospital.					
37. My views are listened to by others on the unit.					
38. We can successfully implement a new program on this unit.					
39. The nurses on the unit actively support each other.					

4. Resource List of Hospitals/Communities that Have Implemented the Program

a) St. Joseph's Hospital, Hamilton, Ontario, in conjunction with the Hamilton-Wentworth Regional Health Unit; Henderson Hospital, Hamilton, Ontario.

b) Community health unit of le Centre hospitalier de Chicoutimi, Chicoutimi, Québec, in conjunction with community health professionals.

c) A multi-agency committee in Winnipeg, Manitoba, consisting of:
Grace General Hospital;
Misericordia General Hospital;
St. Boniface General Hospital;
Victoria General Hospital;
Women's Hospital (HSC);
City of Winnipeg Health Department;
Winnipeg Region, Manitoba Health;
plus all hospitals and public health units throughout the province.

d) St. Rita Hospital, Sydney, Nova Scotia, in conjunction with the Public Health Department.

e) A number of other hospitals and community health agencies in Ontario attended the workshops given by the staff of St. Joseph's Hospital in 1983/84.